

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2194

02172

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville Md.</u>				c. LENGTH OF STAY IN 1b <u>15 mos</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1512 Chillum Road</u>				d. STREET ADDRESS <u>1512 Chillum Road,</u>			
3. NAME OF DECEASED (Type or print) <u>John Dulaney Ames</u>		4. DATE OF DEATH <u>2</u> <u>13</u> <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1902</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balt. more, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edgar A. P. Ames</u>				14. MOTHER'S MAIDEN NAME <u>Susan Elizabeth Eader</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Lillian Mae</u> Address <u>same address (wife)</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1958</u> to <u>July 13, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Sept 10, 1960</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert F. Dyer</u>				22b. DATE SIGNED <u>2/13/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. DYER, M.D.</u>				22d. ADDRESS <u>1835 Eye St. NW Wash. DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>2901 14th N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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SECRET
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301
1011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS				d. STREET ADDRESS 7603 MORRIS AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT RETTIG ANDERSON				4. DATE OF DEATH Month Day Year FEBRUARY 10 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 JUN 1908	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAINING OFFICER				10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT C. S.		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME --				14. MOTHER'S MAIDEN NAME RUTH SWENON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W. W. 2				16. SOCIAL SECURITY NO. 213-38-7324		17. INFORMANT Address COY SEVIER LT COL USAF AAFB	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 hr 15 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 10 FEB 19 61 10 FEB 19 61	
21. I certify that (I) (this hospital) attended the deceased from 10 FEB 19 61 to 10 FEB 19 61 that (I) (we) last saw the deceased alive on 10 FEB 19 61 , and that death occurred at 4:15 PM from the causes and on the date stated above.							
22a. SIGNATURE Andrew W. Butchko M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11 FEB 61	
22c. PHYSICIAN'S NAME (Type) ANDREW W. BUTCHKO CAPT USAF MC				22d. ADDRESS USAF HOSP AAFB CAMP SPRINGS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2/11/61		23c. NAME OF CEMETERY OR CREMATORY Milton Mills Cemetery		23d. LOCATION (City, town, or county) (State) Milton Mill, Hampshire New	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W.				25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

Page 4

2196

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02174

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>1</u> d. STREET ADDRESS <u>W. Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Baranski</u> Last <u>Baranski</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-61</u>
9. AGE (In years lost birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>30</u>	11. IF UNDER 24 HRS. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Prince Geo Co - Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lawrence H. Baranski</u>	
14. MOTHER'S MAIDEN NAME <u>Irene Blanche Uliniski</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary embolism</u> 761.5 DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Premature Rupture of Membranes 21 weeks</u> DUE TO (c) <u>Premature Rupture of Membranes 21 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 25</u> , 1961, to <u>Feb 25</u> , 1961, that (I) (we) last saw the deceased alive on <u>Feb 25</u> , 1961, and that death occurred at <u>2:20</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Francis Warren</u>		22b. DATE SIGNED <u>Feb 25</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Francis Warren</u>		22d. ADDRESS <u>6805 Baltimore Ave. College Park - Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 27, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. House</u>		25a. REC'D BY REGISTRAR <u>Arthur E. House</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. House</u>		DATE <u>FEB 28 '61</u>	

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STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02175

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Upper Marlboro		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Jean Barnett				4. DATE OF DEATH Month Day Year February 3 19 61			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 8, 1958 2 yrs.	
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Nathaniel Barnett				14. MOTHER'S MAIDEN NAME Barbara Jean Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Barbara Jean Barnett, Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916-0 Universal first, second and third degree burns Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In a room that had an oil stove that caught on fire					
20c. TIME OF INJURY Month, Day, Year 12:15 p.m. 2 / 3 / 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL-SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 2/3/61		Address (Street, city, town, or county) xxxx			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-7-61		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mason		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md	
23. FUNERAL DIRECTOR Address Harry S. Washington & Sons 4925 Bloomingdale		24a. REC'D BY REGISTRAR DATE FEB 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

VS. A15ME
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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J. E. R. King

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02176

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS Upper Marlboro			
3. NAME OF DECEASED (Type or print) First Middle Last James Nathaniel Barnett				4. DATE OF DEATH Month Day Year February 3 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1956 4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Nathaniel Barnett				14. MOTHER'S MAIDEN NAME Barbara Jean Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Barbara Jean Barnett, same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal first, second and third degree burns DUE TO (b) 9/16/0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In room in which a stove caught on fire			
20c. TIME OF INJURY Month, Day, Year 12:15 p.m. 2 / 3 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/3/61			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-7-61		22c. NAME OF CEMETERY OR CREMATORY Masons		22d. LOCATION (City, town, or country) (State) Upper Marlboro Md	
23. FUNERAL DIRECTOR ADDRESS Henry S. Washington & Son 4925 Boone Ave NE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
				DATE FEB 8 '61			

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02177

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year				
Melvin Clyde Barnett			February 3, 19 61				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1957		9. AGE (In years, first birthday) 3 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Nathaniel Barnett				14. MOTHER'S MAIDEN NAME Barbara Jean Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Bragara Jean Barnett, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal 1st, second and third degree burns DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. TIME OF INJURY 2:15 PM 2/3/ 61		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Upper Marlboro P.G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED 2/3/61			
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-7-61				22b. DATE THEREOF 2-7-61		22c. NAME OF CEMETERY OR CREMATORY Maus	
22d. LOCATION (City, town, or country) Upper Marlboro Md				22e. REC'D BY REGISTRAR			
23. FUNERAL DIRECTOR Penny Washington				ADDRESS 4925 Gleane Ave NE		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
VS. A15ME SM 7/59				DATE FEB 8 '61			

1995



VR A15 (4)
1SM 9/59

2200

02178

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Hr. 20 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		47	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 4409 30th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Jessie		Middle L.		Last Battley	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month February	
				B. DATE OF BIRTH 4-30-1898		Day 15	
				9. AGE (In years last birthday) 62		Year 19 61	
				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
				11. BIRTHPLACE (State or foreign country) Leicester, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Edwards		14. MOTHER'S MAIDEN NAME Cord Casada					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT John P. Battley		Address above Husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Occlusion of Right Coronary Artery DUE TO Coronary Arteriosclerotic Heart Disease (c)						INTERVAL BETWEEN ONSET AND DEATH 4200 hours hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to Feb 15, 1961 , that (I) (we) last saw the deceased alive on Feb 15, 1961 , and that death occurred at 5:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE Leon R. Levitsky				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/15/61	
22c. PHYSICIAN'S NAME (Type) LEON R. LEVITSKY				22d. ADDRESS 3408-R.I.AVE. MT. RAINIER, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				ADDRESS Mt. Rainier Md.		25a. REC'D BY REGISTRAR DATE FEB 20 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1930

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15, 1930*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Signature of physician: *John Doe*
8. Signature of registrar: *John Doe*

9. Signature of informant: *John Doe*
10. Signature of witness: *John Doe*
11. Signature of registrar: *John Doe*
12. Signature of physician: *John Doe*

13. Signature of informant: *John Doe*
14. Signature of witness: *John Doe*
15. Signature of registrar: *John Doe*
16. Signature of physician: *John Doe*

17. Signature of informant: *John Doe*
18. Signature of witness: *John Doe*
19. Signature of registrar: *John Doe*
20. Signature of physician: *John Doe*

21. Signature of informant: *John Doe*
22. Signature of witness: *John Doe*
23. Signature of registrar: *John Doe*
24. Signature of physician: *John Doe*

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02179

1. PLACE OF DEATH a. COUNTY Prince Georges County			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Pennsylvania		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pa RR Spur to Bowie Racetrack			d. STREET ADDRESS 1428 South 10th Street		
3. NAME OF DECEASED (Type or print) DANIEL JOSEPH BELANCIO			4. DATE OF DEATH Month February , Day 2 , Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1903		9. AGE (In years last birthday) yrs. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
13. FATHER'S NAME Girard Belancio			14. MOTHER'S MAIDEN NAME Mary Chusso		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 180-14-4824		17. INFORMANT Salvatore F. Belancio, Philadelphia, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock					
DUE TO (b) Crushing injuries to the head body and extremities					
DUE TO (c) multiple and severe					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in a train that was in a wreck			
20c. TIME OF INJURY Hour 1:00 p.m. Month, Day, Year 2/2/ 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Train	20f. (City or town) Jerricho Park	(County) P. G.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED February 2, 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) February 2, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF FEB 6, 1961	22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS	22d. LOCATION (City, town, or country) (State) YEADON DEL CO., PENNA.		
23. FUNERAL DIRECTOR W. W. Chambers Co., Riverdale, Md.			24a. REC'D BY REGISTRAR FEB 8 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

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M

75X-3

NEW YORK
JAN 10 1901

2901

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
NEW YORK

NAME: George J. J. J.
RESIDENCE: Philadelphia
1234 South 10th Street
Philadelphia, Pa.
BIRTH: July 27, 1900
DEATH: February 2, 1901

SEX: Male
RACE: White
EDUCATION: High School
OCCUPATION: Clerk
MARRIAGE: Single
RELIGION: Catholic
CAUSE OF DEATH: Heart Disease
100-14-4334

EXAMINATION OF THE BODY AND EXAMINATION
OF THE RECORDS AND BOOKS
FURNISHING EVIDENCE TO THE
FOLLOWING EFFECTS:

1. The body was found in a room
on the second floor of the
building at 1234 South 10th Street,
Philadelphia, Pa., on February 2, 1901.

2. The body was found in a room
on the second floor of the
building at 1234 South 10th Street,
Philadelphia, Pa., on February 2, 1901.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2202

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film 2282 3-2-61 et

02180

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) cheverly c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 507 62nd Pl., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Belk		4. DATE OF DEATH Month February Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-92
9. AGE (In years birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORATORY TECH.	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALONZA BELK	
14. MOTHER'S MAIDEN NAME LOUISA ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT MARTHA C. BELK Address 507 62nd Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Generalized arteriosclerosis, many years DUE TO (c) lying cause lost. INTERVAL BETWEEN ONSET AND DEATH Immediate.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 9, 1961 to February 24, 1961 , that (I) (we) last saw the deceased alive on Feb. 24, 1961 , and that death occurred at 7:45 M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas Edison		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) THOMAS EDISON		22d. ADDRESS 1015 Spring St., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-1-61	
23c. NAME OF CEMETERY OR CREMATORY HARMONY NAT'L PARK		23d. LOCATION (City, town, or county) (State) CHAPEL OAKS, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Alex S. Pope,		25a. REC'D BY REGISTRAR FEB 27 '61	
ADDRESS 414-15th St., S.E.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

5055

1

100

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2203

02181

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u> <u>328 Prince George's St Prince George</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>01 Laurel, Md</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hospital</u>				d. STREET ADDRESS <u>1328 Prince George St</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>STELLA A. BENNIE</u>		First Middle Last		4. DATE OF DEATH Month Day Year <u>Feb. 21 1961</u>				
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-08</u>	9. AGE (In years lost birthday) <u>52 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Alexander Washeleski</u>				14. MOTHER'S MAIDEN NAME <u>Isela Mendolshi</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Breast</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.								
22a. SIGNATURE <u>Charles House</u>				22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <u>CHARLES HOUSE</u>				22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cemetery Laurel Md</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Canalean, Laurel Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		

5208

CHIEF CLERK

MADEAM
2020-2021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2204

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 14 Film 6280 2-9-61 et

02182

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN lb 12 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
3. NAME OF DECEASED (Type or print) First Henrietta Middle C. Last Berkley		4. DATE OF DEATH Month 2 Day 3 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-9-90
9. AGE (In years last birthday) 70 yrs.		10. UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	11. UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, DIST. OF COL.	
11. BIRTHPLACE (State or foreign country) UNITED STATES		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME FRANCIS CLAVELOUX		14. MOTHER'S MAIDEN NAME Katherine Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (I)		16. SOCIAL SECURITY NO. MR. WILLIAM N. BERKLEY	
17. INFORMANT (Son) MR. WILLIAM N. BERKLEY		Address ROUTE #4-VIENNA, VIRGINIA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 331x DUE TO (c) 11 days		INTERVAL BETWEEN ONSET AND DEATH 11 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 23 19 61 , to Feb. 3 19 61 , that (I) (we) last saw the deceased alive on Feb. 3 19 61 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Robert B.G. Sasscer		22b. DATE SIGNED Feb 4-61	
22c. PHYSICIAN'S NAME (Type) Dr. Robert B.G. Sasscer		22d. ADDRESS Upper Marlboro. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/8/61	
23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CATHOLIC CEMETERY		23d. LOCATION (City, town, or county) (State) HANOVER, PENNSYLVANIA	
24. FUNERAL DIRECTOR'S SIGNATURE Hysong Funeral Home		25a. REC'D BY REGISTRAR DATE FEB 6 '61	
ADDRESS Wash. D.C.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

2501

7

REPORT OF THE
VETERINARY MEDICAL
OFFICER IN CHARGE
OF THE
VETERINARY HOSPITAL
AT
WASHINGTON, D. C.
FOR THE
YEAR
1911

REPORT OF THE
VETERINARY MEDICAL
OFFICER IN CHARGE
OF THE
VETERINARY HOSPITAL
AT
WASHINGTON, D. C.
FOR THE
YEAR
1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2205

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02183

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> adm. 2-9-50		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		d. STREET ADDRESS <u>LAKE DRIVE APTS.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CECE F. BERNATH</u>		4. DATE OF DEATH <u>FEBRUARY 14</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August - 1873</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE TERDENHEIMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hosp. RECORDS LAUREL SANITARIUM</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>several days</u> several yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis with psychosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>56</u> to <u>Feb 14</u> 19 <u>61</u> that I last saw the deceased alive on <u>2-14-</u> 19 <u>61</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Erika P. Kraemer</u> M.D.		DATE SIGNED <u>LAUREL SANITARIUM 2-14-61</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-16-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Euston Pl</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kenna</u> DATE <u>FEB 15 '61</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

5207

1

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF REGISTRAR

DATE

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2206
CERTIFICATE OF DEATH

02184

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Florence Middle Blaisdell Last Blaisdell			4. DATE OF DEATH Month February Day 16 Year 19 61			
5. SEX Female	6. COLOR OR RACE "hite"	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/70		9. AGE (In years last birthday) 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James Crook			
14. MOTHER'S MAIDEN NAME Emily V. Forsyth			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -----			
16. SOCIAL SECURITY NO. -----			17. INFORMANT Wm. W. Blaisdell-Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism 704.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Fracture of Left Hip secondary to fall at home. DUE TO (c) 5 days						INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Ht. Failure, Mitral Stenosis, Coronary Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Feb., 11 19 61 , to Feb., 16 19 61 , that (I) (we) last saw the deceased alive on Feb 16 19 61 , and that death occurred at 285P , from the causes and on the date stated above.				
22a. SIGNATURE Wm. W. Blaisdell-Cheverly		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/16/61		
22c. PHYSICIAN'S NAME (Type) Prince Georges Hosp. Cheverly, Md.		22d. ADDRESS Prince Georges Hosp. Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-19-61		23c. NAME OF CEMETERY OR CREMATORY Mount View Cemetery		
23d. LOCATION (City, town, or county) (State) West Friendship, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Haight				
25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Haight				

CERTIFICATE OF DEATH

1918

First Name: George
Last Name: George
Sex: Male
Age: 60
Date of Birth: 1858
Place of Birth: [illegible]
Cause of Death: [illegible]
Date of Death: [illegible]
Place of Death: [illegible]

George

Signature of Physician: [illegible]
Signature of Registrar: [illegible]
Date: [illegible]
Place: [illegible]

George George

George George

2025-001-104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2207
077
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1
CERTIFICATE OF DEATH
02185

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Susan Myrtle Brady				4. DATE OF DEATH Month Day Year February 2 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/7/75	
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George W. Higgs				14. MOTHER'S MAIDEN NAME Mary E. Mattingly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Washington, D.C. Mrs. Altie Zecca-1711 Mass. Ave., N.W.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1 Mar 1960 to 2 Feb 1961, that (I) (we) last saw the deceased alive on 2 Feb 1961, and that death occurred at 1:08 from the causes and on the date stated above.							
22a. SIGNATURE R. B. Sasscer				22b. DATE SIGNED 2/2/61			
22c. PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.				22d. ADDRESS Upper Marlboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ritchie Bros. Fun'l Home-Upper Marlboro, Md.				25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

RECEIVED AT DEPARTMENT OF HEALTH
HOSPITAL, 1500 K STREET, N.W., WASHINGTON, D.C. 20004
CERTIFICATE OF DEATH

465

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INDEX

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02186

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville c. LENGTH OF STAY IN lb 47 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11714 Ellington Drive				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 74 Beltsville d. STREET ADDRESS 11714 Ellington Drive a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARIE LOUISE BREWER				4. DATE OF DEATH Month Day Year February 7, 1961.			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1884	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Retired		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Murkurk, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Briggs		14. MOTHER'S MAIDEN NAME Betty Harrison		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None	
16. SOCIAL SECURITY NO. 218-38-7311		17. INFORMANT Mrs. Anna E. Brewer Johnson,		Address 518 F St., N.E., Wash., D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infraction DUE TO (c) Coronary Arteriosclerosis Heart Disease	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 7, 1961.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-11-61		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Queens Chapel Cemetery		22d. LOCATION (City, town, or country) (State) Murkurk, Maryland	
23. FUNERAL DIRECTOR HENRY S. WASHINGTON & SONS NE, Wash. DC		ADDRESS 4925 Dean Ave		10a. REC'D BY REGISTRAR FEB 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (1)
15M 5-59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2209

02187

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 9 Weeks 3 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland Park		d. STREET ADDRESS 1202 69th Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy A. Middle Britt Last Britt		4. DATE OF DEATH Month Feb. Day 10 Year 19 61	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5. 1960
9. AGE (In years lost birthday) 2 yrs		IF UNDER 1 YEAR Months 2 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leon Britt		14. MOTHER'S MAIDEN NAME Barbara Mc Clurkin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive White SubDural Heatoma And Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from Dec. 5 19 61 , to Feb. 10 19 61 , that (I) (we) last saw the deceased alive on Dec. 9 19 61 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>John Perkins</i>		22b. DATE Feb. 11 1961	
22c. PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.		22d. ADDRESS 5301 Hamilton St., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/17/61	
23c. NAME OF CEMETERY OR CREMATORY Pr. Geo. Gen. Hospital		23d. LOCATION (City, town, or county) (State) Cheverly, P.G.Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Adm.		25a. REC'D BY REGISTRAR DATE FEB 21 '61	
25b. REGISTRAR'S SIGNATURE <i>Charles L. House</i>			

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UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERINARY MEDICINE
DIVISION OF ANIMAL INDUSTRY
WASHINGTON, D. C.

2500

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1. Name of the animal

2. Sex and age of the animal

3. Breed of the animal

4. Date of birth

5. Date of death

6. Cause of death

7. Name of the owner

8. Address of the owner

9. Name of the veterinarian

10. Address of the veterinarian

11. Name of the laboratory

12. Address of the laboratory

13. Name of the investigator

14. Address of the investigator

15. Name of the institution

16. Address of the institution

17. Name of the sponsor

18. Address of the sponsor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02188

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN lb 8 HOURS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, WASH 25, DC		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) INDIANHEAD d. STREET ADDRESS BOQ, US NAVAL PROPELLANT PLANT e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle W Last BROADBENT		4. DATE OF DEATH Month FEBRUARY Day 17 Year 19 61	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 AUGUST 1935
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months 25	11. IF UNDER 24 HRS. Hours 25 Min. 08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US NAVAL OFFICER		10b. KIND OF BUSINESS OR INDUSTRY US NAVY	
11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME DONALD BROADBENT		14. MOTHER'S MAIDEN NAME BARBARA M ZAUGG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1957 - 1961 031-266-3346	
17. INFORMANT PERSONNEL AND HOSPITAL CHARTS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE FRACTURES, LEFT FEMUR & TIBIA, RIGHT RADIUS & ULNA DUE TO CRANIAL CEREBRAL INJURY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE LACERATIONS, LEFT AXILLA & RIGHT LEG DUE TO (c) 8 HOURS INTERVAL BETWEEN ONSET AND DEATH 8 HOURS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) INVOLVED IN 3 CAR COLLISION ON RT #210, GLYMONT, MD		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) INVOLVED IN 3 CAR COLLISION ON RT #210, GLYMONT, MD	
20c. TIME OF INJURY Month, Day, Year 11:45 p.m. Feb 16 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MD ROUTE 210		20f. (City or town) (County) (State) GLYMONT CHARLES MD	
21. I certify that (I) (this hospital) attended the deceased from 17 FEBRUARY 19 61 to 17 FEBRUARY 19 61 , that (I) (we) last saw the deceased alive on 17 FEBRUARY 1961 , and that death occurred at 9:45A M, from the causes and on the date stated above.			
22a. SIGNATURE <i>John A. Hennesen Jr.</i>		22b. DATE 17 FEBRUARY 1961	
22c. PHYSICIAN'S NAME (Type) JOHN A HENNESSEN JR, LT COL USAF MC USAF HOSP, ANDREWS AFB, WASH 25, DC		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/21/61	
23c. NAME OF CEMETERY OR CREMATORY BIRCHWOOD CEMETERY CENTERVILLE MASS.		23d. LOCATION (City, town, or county) (State) MASS.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co. Inc.</i>		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
ADDRESS 1400 Chapin St NW WASHINGTON, D.C.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

DEPARTMENT OF HEALTH

8216

THE STATE OF NEW YORK
IN SENATE
JANUARY 1, 1914
REPORT
OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR
1913
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1914

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FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

221 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02189

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D. C. b. COUNTY None c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4620 Iowa Avenue N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES WOODMAN BRODERICK				4. DATE OF DEATH Month February Day 18 , Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1900	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Planning Manager		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT. Printing		9. AGE (In years last birthday) 60 yrs.		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Broderick		14. MOTHER'S MAIDEN NAME Kathleen Cavanaugh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mabel I. Broderick,		Address 4620 Iowa Avenue N. W., Washington, D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Severe Coronary Atherosclerosis DUE TO (c) Severe Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED February 19, 1961.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/61		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		22d. LOCATION (City, town, or country) (State) Arlington Va.	
23. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 3821 14th St., N.W., Wash. DC.		24a. REC'D BY REGISTRAR FEB 21 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

NEW YORK
JULY 2, 1903

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Prison Department

Prison

Prison George General Hospital

JAMES

WOLMAN

PROBATION

Prison

Male

Male

Prison Manager

U.S. Prison

Massachusetts

James Probation

Prison Department

For

Prison

Prison, U.S. Prison, U.S.

Prison, Probation

Prison, Probation

Prison, Probation

Prison, Probation

Prison, Probation

Prison, Probation

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02190

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2212 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		43	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		c. LENGTH OF STAY IN 1b 2 Hr 10 Min		d. STREET ADDRESS 3022 Kennilworth Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby girl		First Brown		Middle Brown		Last Brown	
4. DATE OF DEATH Month Feb. Day 7 Year 61		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 7. 1961		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 10		IF UNDER 24 HRS. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald J. Brown		14. MOTHER'S MAIDEN NAME Josephine Barnes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 7 1961 to Feb. 7 1961 , that (I) (we) last saw the deceased alive on Feb. 7 1961 , and that death occurred at 2:10 PM , from the causes and on the date stated above.		22a. SIGNATURE John W Perkins		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.	
22d. ADDRESS 5301 Hamilton St., Hyattsville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/28/61		23c. NAME OF CEMETERY OR CREMATORY Pr. George's Gen. Hospt.	
23d. LOCATION (City, town, or county) (State) Cheverly, P.G. County, Md.		24. FUNERAL DIRECTOR'S SIGNATURE HARRY W. PENN, ADM.		25a. REC'D BY REGISTRAR MAR 7 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

CERTIFICATE OF HEALTH

1912

State of _____
County of _____
City of _____

I, _____, of the County of _____, State of _____, do hereby certify that _____

is a resident of the County of _____, State of _____, and that he is a citizen of the United States of America.

Witness my hand and seal this _____ day of _____, 1912.

[Signature]
Notary Public for the State of _____

Subscribed and sworn to before me this _____ day of _____, 1912.

[Signature]
Notary Public for the State of _____

ORIGINATOR: _____
DATE: _____

CERTIFICATE OF DEATH

Reg. Dist. No. 18191

2213

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

District of Columbia

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Adelphi

c. LENGTH OF STAY IN 1b

2 yrs. 1 mo

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

47X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Paint Branch Nursing Home

d. STREET ADDRESS

1607 Eastern Ave.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Berse

Brinton

Brown

4. DATE OF DEATH

Month

Day

Year

Feb.

8

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Mar. 28, 1878

9. AGE (In years last birthday)

72 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard Duty

10b. KIND OF BUSINESS OR INDUSTRY

St. Elizabeths Hosp

11. BIRTHPLACE (State or foreign country)

Broad top, Penn.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph. Brown

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

None

INFORMANT

Address

Nursing Home Records.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Vascular Accident

DUE TO

331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

Hypertension

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 Days

Several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m.20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1-8, 1960, to 2-8, 1961, that I last saw the deceased alive on 2-6, 1961, and that death occurred at 7:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE

Stuart L. Nelson

M.D.

ADDRESS (Street, city or town, state)

7600 Carroll Ave. Takoma Park, Md. 2-8-61

DATE SIGNED

PHYSICIAN'S NAME (Type)

STUART L. NELSON M.D.

22a. BURIAL CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

2-9-61

22c. NAME OF CEMETERY OR CREMATORY

W. of Md. Med. School

22d. LOCATION (City, town, or county)

Balti. more, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE FEB 10 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

2813

CERTIFICATE OF DEATH

George Washington

Age 72

Residence 1234 Main St. N. 2. A.

Occupation Farmer

72

No Home Nursing Home Records.
Joseph Brown
Guard Duty St. Elizabeths Hosp Broad St, Penn. N. 2. A.

02192

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 43 Hyattsville d. STREET ADDRESS 15510 Randolph Street	
3. NAME OF DECEASED (Type or print) JOHN First Middle 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder 10b. KIND OF BUSINESS OR INDUSTRY Printing		4. DATE OF DEATH Month Day Year February 25, 1961. 8. DATE OF BIRTH July 8, 1912 9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Burns 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 11 16. SOCIAL SECURITY NO. 17. INFORMANT Ellen Redmond Address Mrs Madeleine Burns, Same as # 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary insufficiency (b) Cardiovascular renal disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 26, 1961	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/28/61 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 22d. LOCATION (City, town, or country) (State) Colmar Manor, Maryland	
23. FUNERAL DIRECTOR Francis Gasch's Sons ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

RECEIVED
JAN 10 1961

(M)

Prison Georges County

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Prison Georges County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2218
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02196

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		d. STREET ADDRESS 3910 Laurel Rd	
3. NAME OF DECEASED (Type or print) Nellie L. Cook		4. DATE OF DEATH February 11 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31 1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lucas		14. MOTHER'S MAIDEN NAME Helia Elizabeth Whittle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Nellie Fairall		Address Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Acute Cordial Dehiscence (b) Arteriosclerosis (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs 1 1/2 20	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 130 to 2/11 1961, that (I) (we) last saw the deceased alive on 2/10 1961, and that death occurred at 150M, from the causes and on the date stated above.			
22a. SIGNATURE B.P. Warren		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) B.P. WARREN		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/61	
23c. NAME OF CEMETERY OR CREMATORY East Lincoln Cem.		23d. LOCATION (City, town, or county) (State) Calmar Manor Md	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
DeWitt Davidson Laurel Md		DATE FEB 20 '61	
25b. REGISTRAR'S SIGNATURE		Arthur S. Kraus	

8188

(1)

(1)

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Discernible words include:]
Name of deceased
Age
Sex
Date of birth
Date of death
Place of birth
Cause of death
Signature of physician
Signature of registrar
Date of registration

2215

02193

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 1104 Raydale Rd.	
3. NAME OF DECEASED (Type or print) Nathan		4. DATE OF DEATH Month Feb Day 6 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Painter	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Cannon		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Sadie Schnapp	
17. INFORMANT W. Hyattsville		Address 1104 Raydale Rd Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 YRS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) THROMBOSIS, RT MID CEREBRAL ARTERY			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Jan Day 1 Year 1958 Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 1 1958 to FEB 6 1961 that (I) (we) last saw the deceased alive on FEB 6 1961 , and that death occurred at 1.00 AM from the causes and on the date stated above.			
22a. SIGNATURE Samuel J. N. Sugar		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR		22d. ADDRESS MT. RAINIER, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-61	
23c. NAME OF CEMETERY OR CREMATORY Montefiore Cemetery		23d. LOCATION (City, town, or county) (State) Springfield L.I., N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE FEB 8 '61	

2815

CHARTER OF DEATH

1000

CHARTER

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sutland</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sutland</u>					
c. LENGTH OF STAY IN 1b <u>4 mo</u>						d. STREET ADDRESS <u>13 Summers Road</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 Summers Road</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Theresa Anna Coffman</u>						4. DATE OF DEATH <u>Feb 14 1961</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Oct 17, 1960</u>					
9. AGE (In years last birthday) <u>3</u> yrs. <u>3</u> months <u>29</u> days						10. IF UNDER 1 YEAR <u>3</u> months <u>29</u> days					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>					
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Eldon Coffman</u>						14. MOTHER'S MAIDEN NAME <u>Ida Riggs</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>none</u>					
17. INFORMANT <u>Mrs Ida Coffman</u>						Address <u>same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (e) <u>Pneumonia</u> DUE TO (b) <u>X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>X</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED <u>Feb 14, 1961</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>2-16-61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>											
22d. LOCATION (City, town, or country) (State) <u>Arlington Natl.</u>											
23. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>1661-6004 Hope Rd SE WASH 20 DC</u>											
24a. REC'D BY REGISTRAR <u>FEB 15 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>											

VS. A19ME
5M 1/39

How

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copy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2219

02197

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN TB unknown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4702 Huron Avenue				d. STREET ADDRESS 4702 Huron Avenue			
3. NAME OF DECEASED (Type or print) First Agatha Middle Cosimano Last Cosimano				4. DATE OF DEATH Month Feb. Day 2 Year 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/25/1883	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Italy	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph Cosimano (same as above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic myocarditis (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-22-1960 to Feb. 1, 1961 , that (I) (we) last saw the deceased alive on Jan. 31, 1961 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Eugene A. Forcione, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 2, 1961	
22c. PHYSICIAN'S NAME (Type) EUGENE A. FORCIONE				22d. ADDRESS 2100 Conn. Ave. N.W.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				25a. REC'D BY REGISTRAR FEB 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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11.6.2014

Wm. H. Jones Co., Washington, D. C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02198											
1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie c. LENGTH OF STAY IN 1b Pa. RR Spur to Bowie Race Track d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) York d. STREET ADDRESS RD 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FREDERICK			First WORMAN			Middle CRAMER JR.			Last February 2, 19 61		
4. DATE OF DEATH			Month			Day			Year		
5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH January 23, 1912		
9. AGE (in years last birthday) 49			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator			11. BIRTHPLACE (State or foreign country) York Stone Supply Co. Frederick, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frederick Worman Cramer Sr.						14. MOTHER'S MAIDEN NAME Nina Marshall					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown No Unknown No Unknown						16. SOCIAL SECURITY NO. 187-24-0382					
17. INFORMANT Mrs. Dorothy May Cramer, RD2, York, Pa.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushed skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Passenger of a train that was in a wreck							
20c. TIME OF INJURY Month, Day, Year 1:00 p.m. 2/2 19 61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Train			
20f. (City or town) Jerricho Park				20g. (County) P. G.				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED February 2, 1961											
ACTUAL SIGNATURE James I. Boyd											
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF FEB 6, 1961				22c. NAME OF CEMETERY OR CREMATORY York, Pennsylvania.			
22d. LOCATION (City, town, or country) York, Pennsylvania.				22e. (State) York, Pennsylvania.				22f. (Country) York, Pennsylvania.			
23. FUNERAL DIRECTOR W.W. CHAMBERS CO.,						ADDRESS Riverdale, Maryland.					
24a. REC'D BY REGISTRAR FEB 8 '61						24b. REGISTRAR'S SIGNATURE Charles L. Haines					

MEDICAL CERTIFICATION

NEW YORK STATE
DEPARTMENT OF HEALTH

32250

68138

James George Conlin

Home York

1st, 2nd Ave to Bowls Lane Track

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2216

02199

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. LENGTH OF STAY IN 1b 3 Months		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo's Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights, Maryland		d. STREET ADDRESS 7118- District Heights Parkway		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First		Middle F.		Last ORISTY		4. DATE OF DEATH Feb. 27th		Month		Day		Year 19 61	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23- 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Robert C. Mc Olvin		14. MOTHER'S MAIDEN NAME Mary Pickering													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes give number or dates of service)		17. INFORMANT Nelson G. Cristy		Address Same as # 2.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-1 DUE TO (b) Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive arteriosclerotic Coronary H.D. 5-6 yrs. (b) Coronary Occlusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 3-4 Days 7-8 Days													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Nov		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 19 60 to 27 Feb 1961, that (I) (we) last saw the deceased alive on Feb 26 1961, and that death occurred at 10 PM, from the causes and on the date stated above.															
22a. SIGNATURE Sidney W. Lowry		22b. DATE SIGNED 2/27/61		22c. PHYSICIAN'S NAME (Type) S. W. LOWRY M.D.		22d. ADDRESS 7200- MARLBORO PIKE SE									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 2-61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) Fairmont, West Virginia									
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		1661- Good Hope Road SE Washington 20, DC.		25a. REC'D BY REGISTRAR DATE MAR 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines									

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STATE OF DEATH

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02200

2221

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 4105 82nd Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Howard First Dalby Middle Dalby Last				4. DATE OF DEATH Feb. 24 1961 Month Day Year											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/29/1884		9. AGE (In years last birthday) 76 rs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer				11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Richard Dalby				14. MOTHER'S MAIDEN NAME Mary Jackson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service) National Guard		17. INFORMANT Ethel Dalby (wife) Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 420.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO (c) Hypertensive arteriosclerosis Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks 8-10 yrs												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sept 1958 Feb 24 1961		(County) Washington		(State) MD			
21. I certify that (I) (this hospital) attended the deceased from Sept 1958 to Feb 24 1961 , that (I) (we) last saw the deceased alive on Feb 24 1961 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.															
22a. SIGNATURE S. W. Lowry 22c. PHYSICIAN'S NAME (Type) S. W. LOWRY M.D.				22b. DATE SIGNED M.D.		22d. ADDRESS 17200-MARLBORO PIKE S.E. WASH DC.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 27, 1961		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery				23d. LOCATION (City, town or county) Smithland Md.		(State) MD			
24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee				ADDRESS Wash. D. C.		25a. REC'D BY REGISTRAR DATE FEB 28 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Travis					

2291

Prince George

Porterville

Howard

Male

Richard

Richard

X

John

Richard

Maryland

Porterville

1102 2nd ave

John

3/2/1924

Tennessee

John Jackson

Richard (wife)

U. S. A.

CERTIFICATE OF DEATH

Reg. Dist. No. 02201

2222

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. LENGTH OF STAY IN 1b <u>SEVERN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL GENERAL Hospital</u>				d. STREET ADDRESS <u>Box 14, MINNIETORKA ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>William</u> Last <u>DARNELL</u>				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/22/ 1900</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>molder helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>			
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>ESTELLE DARNELL, wife, SAME</u>			
17. INFORMANT <u>ESTELLE DARNELL</u>				Address <u>wife, SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral & General Arteriosclerosis</u> DUE TO <u>Stasis Pneumonia</u> (c) <u>Stasis Pneumonia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>61</u> , to <u>2-11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>61</u> , and that death occurred at <u>11:40 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Idolo Pierandrei</u> M.D.				ADDRESS (Street, city or town, state) <u>LAUREL, M.D.</u>			
DATE SIGNED <u>2/11/61</u>							
PHYSICIAN'S NAME (Type) <u>IDOLO PIERANDREI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/14/61</u>		<u>Sanage Cemetery</u>		<u>Sanage Rd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Donaldson</u>				ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 20 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02202

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine		c. LENGTH OF STAY IN 1b 4 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALLEN de CHANEY				4. DATE OF DEATH Month February Day 11 , Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 69 yrs.		9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months 2 Days 69	IF UNDER 24 HRS. Hours 69 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist - Retired		10b. KIND OF BUSINESS OR INDUSTRY Drugs.		11. BIRTHPLACE (State or foreign country) Hungry.		12. CITIZEN OF WHAT COUNTRY? Unknown ✓	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address #6 Petercooper Rd., New York, New York. Mrs. Dorothy Stephenson,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal Charring burns of Body 9/16.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fire in house he was staying which burned to the ground.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:05 Feb. 11, 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Brandywine, P.G. Cty., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED February 11, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-61		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or country) (State) Suitland Maryland	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR DATE FEB 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

1

RECEIVED BY THE STATE OF NEW YORK

1933

DEPARTMENT OF HEALTH

James George Conley
Franklin
James
Alfred
de la Cruz
February 11, 1933

Male
White
Married
Unknown
Unknown
New York, New York
February 11, 1933

1:01 PM, Feb. 11, 1933
This is house he was staying which turned to the ground.
February 11, 1933

JAMES I. MOY, M.D.
February 11, 1933

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Prince Georges County		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Riverdale		Green Meadows	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Leland Memorial Hospital		2029 Roanoke Avenue	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
HAROLD (NMN) DELCHAMP		February 11, 1961	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	White		March 7, 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Taxi Driver		Diamond Cab Co.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Joseph Delchamp		Catherine Zinno	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
Mr. Joseph Delchamp		10018 Clue Court, Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		Only about 420.0	
DUE TO (b) Atherosclerotic Heart disease			
DUE TO (c) E			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Cirrhosis of the liver & Ascites			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour o. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-21-1961 to 2-9-1961 that (I) (we) last saw the deceased alive on 2-9-1961, and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
D. R. Purdie		9/11/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
D. R. PURDIE, M. D.		4408 Queensbury Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Feb. 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Mount Olivet Cemetery		Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
W. W. CHAMBERS CO.,		DATE FEB 14 '61	
Riverdale, Maryland.		25b. REGISTRAR'S SIGNATURE	
		Arthur L. Hines	

1933

State of New York
County of New York
In SENATE
January 1, 1933
The People of the State of New York, represented by Senators
of the County of New York, do hereby certify that the following
is a true and correct copy of the original of the same as
the same is on file in the office of the Secretary of State
of the State of New York.

Attest:
Secretary of State

Witness my hand and the seal of the State of New York
this 1st day of January, 1933.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03416

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4612 Lewis Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry Everett DeSmar</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 20, 1883</u>	
9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Thomas DeSmar</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Richardson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-16-0315</u>			
17. INFORMANT <u>Arthur DeSmar</u>				Address <u>185-64th St. Bay Ridge, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyle</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyle</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>2-26-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l Cem. Suitland, Md.</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR ADDRESS <u>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

1911

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1911

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02204

2226

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>5402-KENILWORTH AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>ANNE</u> Last <u>DEMERYLY</u>		4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10-1877</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>SCRANTON, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN ABLANALP</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA LUTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM CALLAGHAN, RIVERDALE AVE</u>		Address <u>5402-KENILWORTH</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknow cause. Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/14</u> , 19 <u>61</u> , to <u>2/14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>61</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5702 annapolis Rd</u> DATE SIGNED <u>4/15/61</u>			
ACTUAL SIGNATURE <u>Barry Rosenberg</u>		M.D. <u>5702 annapolis Rd</u>	
PHYSICIAN'S NAME (Type) <u>BARRY ROSENBERG</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/18/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	22d. LOCATION (City, town, or county) (State) <u>ARMOR NEW YORK 5</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shaffell</u>		ADDRESS <u>4754 4th St. N.W. Wash D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Peters</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		M		45		1880		BALTIMORE, MD		LABORER		MARRIED		HEART DISEASE		BALTIMORE, MD		10:30 AM		J. H. HARRIS		J. H. HARRIS	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF BURIAL		21. NAME OF CREMATION		22. NAME OF URN		23. NAME OF CASK		24. NAME OF COFFIN	
BALTIMORE, MD		ST. MARY'S CHURCH		10/15/1925		J. H. HARRIS		ST. MARY'S CHURCH		J. H. HARRIS		ST. MARY'S CHURCH		ST. MARY'S CHURCH		ST. MARY'S CHURCH		ST. MARY'S CHURCH		ST. MARY'S CHURCH		ST. MARY'S CHURCH	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO BE FILLED OUT BY THE PHYSICIAN OR REGISTRAR

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. PLACE OF INTERMENT

14. NAME OF INTERMENT

15. DATE OF INTERMENT

16. NAME OF MINISTER

17. NAME OF CHURCH

18. NAME OF FUNERAL HOME

19. NAME OF CEMETERY

20. NAME OF BURIAL

21. NAME OF CREMATION

22. NAME OF URN

23. NAME OF CASK

24. NAME OF COFFIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2228
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02206

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, DC. b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR-4922 L. SALLE		d. STREET ADDRESS 4607-CONN. AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MISS SARAH - MAGDELINE - DOUGHERTY		4. DATE OF DEATH FEBRUARY 17 19 61	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1895 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT WORKER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? YES - U.S.A.	
13. FATHER'S NAME DAVID FRANCIS DOUGHERTY		14. MOTHER'S MAIDEN NAME MARY TOLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Sister M. Denis Catherine		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X Pneumonia - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parkinsonism & weakness of muscles & dysphagia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1957 to 2/17, 1961 , that (I) (we) last saw the deceased alive on 2/16, 1961 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward J Pacious		22b. DATE SIGNED 2/17/61	
22c. PHYSICIAN'S NAME (Type) EDWARD J PACIOUS		22d. ADDRESS 1746 K ST. N.W. Wash, DC.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-1961	
23c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons, Wash, DC.		25a. REC'D BY REGISTRAR DATE FEB 20 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

3538

(17)

REPORTED BY: [illegible] DATE: [illegible]
PLACE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

EDWARD J. PATRICK

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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2229

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02207

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AQUASCO</u>		c. LENGTH OF STAY IN 1b <u>X</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AQUASCO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BABY BOY</u> Middle <u>—</u> Last <u>DOUGLAS</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-61</u>
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>AQUASCO, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John A. Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Louise Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John A. Carroll</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 SUFFOCATION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>—</u> 19 <u>—</u> to <u>2-6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>—</u> 19 <u>—</u> , and that death occurred at <u>10:15</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Dobson</u>		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. DOBSON, M.D.</u>		22d. ADDRESS <u>BRANDY WINE, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley M.E.</u>	23d. LOCATION (City, town, or county) (State) <u>AQUASCO, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Nelson-Aquasco, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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CERTIFICATE OF DEATH

8250

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ENCLOSURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
2230					02208					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY Prince Georges MARYLAND					a. STATE D. C. b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital					d. STREET ADDRESS D. C. Village					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year		
Juanita			L. Duncan			2		4 19 61		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/27/09		9. AGE (In years lost birthday) 51 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General housework		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Samuel Duncan					14. MOTHER'S MAIDEN NAME Lena ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -		17. INFORMANT Decedent		Address -			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic rheumatoid arthritis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/27/1961 to 2/4/1961, that (I) (we) last saw the deceased alive on 2/4/1961, and that death occurred at 2:58 P. M. from the causes and on the date stated above.										
22a. SIGNATURE Moe Weiss					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/4/1961			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2/9/61		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. McNamee					ADDRESS 1820 94th St NW WASHINGTON DC		25a. REC'D BY REGISTRAR DATE FEB 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

EXTRACT OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 03420

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rt 2 Box 36</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oscar H Entzian</u>		4. DATE OF DEATH Month Day Year <u>Feb. 20 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-01</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming Tobacco</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rudolph Entzian</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Unknown Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Josephine Entzian</u>		Address <u>Rt 2, Box 36 Mitchellsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO <u>4 months</u> (c) <u>10 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 24, 1960</u> , to <u>Feb. 20, 1961</u> , that I last saw the deceased alive on <u>Feb. 20, 1961</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>RT #1 Box 277 - M</u> <u>3/20/61</u>			
ACTUAL SIGNATURE <u>Sylvia M. Kim</u>		M.D. <u>Edgewater, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sylvia M. Kim</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/23/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bess</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02209

1. PLACE OF DEATH a. COUNTY Prince Geo MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Geo 34									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park Hyattsville 1									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deland Mem Hosp				d. STREET ADDRESS 8106 Pembroke Pl e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Leon Richard Faircloth				4. DATE OF DEATH February 9 1961									
5. SEX m		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-12-1901 59 yrs.		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman				10b. KIND OF BUSINESS OR INDUSTRY E.H. WALKER CO.				11. BIRTHPLACE (State or foreign country) N. CAROLINA				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Wesley Faircloth				14. MOTHER'S MAIDEN NAME Rich, Harriett E									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 579-01-5638				17. INFORMANT Hosp. Rec. & Daughter.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260 X DUE TO Cerebral Artery occlusion right (b) ARTERIOSCLEROSIS - (c) DUE TO DIABETES Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) severe sore of both feet										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb 1 1961, to Feb 8 1961, that (I) (we) last saw the deceased alive on Feb 9 1961, and that death occurred at 8:30 PM, from the causes and on the date stated above.													
22a. SIGNATURE R. Williamson MD				22b. DATE SIGNED 2-9-61				22c. PHYSICIAN'S NAME (Type) R. WILLIAMSON				22d. ADDRESS Deland Memorial Hospital, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 2-11-1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Blacksburg Md.					
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co				ADDRESS Riverdale, Md.				25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

9037

NAME OF DECEASED *John J. Smith*

RESIDENCE *123 Main Street, New York City*

DATE OF DEATH *April 15, 1912*

PLACE OF DEATH *Home*

CAUSE OF DEATH *Heart Disease*

AGE *65*

SEX *Male*

EDUCATION *High School*

OCCUPATION *Teacher*

RELIGION *Catholic*

DATE OF BIRTH *March 1, 1847*

PLACE OF BIRTH *New York City*

DATE OF MARRIAGE *June 1, 1870*

NAME OF SPOUSE *Elizabeth Smith*

DATE OF INTERMENT *April 17, 1912*

PLACE OF INTERMENT *St. Mary's Cemetery*

NAME OF MINISTER *Rev. John J. Smith*

NAME OF CLERGYMAN *Rev. John J. Smith*

2233

CERTIFICATE OF DEATH

Reg. Dist. No. 03422

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie				c. LENGTH OF STAY IN 1b 1 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's County Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Ferguson				4. DATE OF DEATH Month February Day 25, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1884	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elijah Ferguson				14. MOTHER'S MAIDEN NAME Victoria Richardson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) Unknown		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Harvey Leon Ferguson Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute Congestive Cardiac failure DUE TO (b) Arteriosclerotic myocarditis DUE TO (c) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 hr Unknown Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Hypochromic Anemia Duration Unknown							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Natural Causes				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 15, 1961, to Feb 25, 1961, that I last saw the deceased alive on Feb 24, 1961, and that death occurred at 2:45 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul C. VanNatta, M.D.				ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE Washington 28 DC			
DATE SIGNED 2/25/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE MAR 13 '61		24b. REGISTRAR'S SIGNATURE Charles L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02210

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>04</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>		d. STREET ADDRESS <u>15th and Chestnut Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE</u> <u>FLETCHER</u>		4. DATE OF DEATH Month Day Year <u>FEB 25</u> <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-95</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Grayson</u>		14. MOTHER'S MAIDEN NAME <u>Math Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>CLARA MARSHALL - 4374 Dubois St SE</u>	
17. INFORMANT <u>CLARA MARSHALL</u>		Address <u>4374 Dubois St SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO 155.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>PRIMARY CANCER IN THE GALLBLADDER</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>61</u> , to <u>2-25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>FEB 25</u> , 19 <u>61</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R.B. Barnes</u>		22b. DATE SIGNED <u>2-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. R. Sasser</u>		22d. ADDRESS <u>2-26-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-1-61</u>		23b. DATE THEREOF <u>3-1-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Church of the Resurrection</u>		23d. LOCATION (City, town, or county) (State) <u>Bowie Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Barnes & Matthews</u>		25a. REC'D BY REGISTRAR <u>3619-14 St NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>FEB 27 '61</u>	

1950

UNITED STATES OF AMERICA

1950

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2235

CERTIFICATE OF DEATH

Reg. Dist. No. 02211

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale, Md				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles First Irving Middle Flory Last				4. DATE OF DEATH February Month 7, Day 19 61 Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister Retired				10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Charles Flory				14. MOTHER'S MAIDEN NAME Margaret Cost			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Maurice Flory Address Seabrook Maryland.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Vascular Accident Hemiplegia DUE TO arteriosclerosis generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) year DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arteriosclerotic Heart Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 19 60 to 2/7 1961 , that I last saw the deceased alive on 2/7 1961 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) RFD Bowie Md DATE SIGNED 2/7/61 ACTUAL SIGNATURE H. James Kurtz M.D. R F D Bowie, Maryland. PHYSICIAN'S NAME (Type) H. James Kurtz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 10, 1961		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR FEB 10 '61 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0281

Prince George's

axial

Prince George's

Almond Dale, Md.

Almond Dale, Md.

XX

0281

Germany

84

March 3, 1973

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02212

1. PLACE OF DEATH a. COUNTY Prince George County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS Route #2, Box 415 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) NORRIS CAMPBELL FOWLER			4. DATE OF DEATH Month Day Year February 9, 19 61.		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1891		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Lanham, Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 517-10-9927		17. INFORMANT Mrs. Gladys M. Fowler, Address: Route 2 Box 415 Clinton, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 9, 1961					
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		Address (Street, city, town, or county) February 9, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 14, 1961	22c. NAME OF CEMETERY OR CREMATORY Lanham Meth. Ch. Cemetery		22d. LOCATION (City, town, or country) Lanham, Maryland.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.		ADDRESS Riverdale, Maryland.		24a. REC'D BY REGISTRAR 14 61	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

2238

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1935

Prince George's	Howard	Prince George's County	Unusually	U. S. A.	Clinton
Route 2, Box 15	Route 2, Box 15	Prince George's General Hospital	Prince George's General Hospital	Route 2, Box 15	Clinton
February 9, 1935	February 9, 1935	February 9, 1935	February 9, 1935	February 9, 1935	February 9, 1935
White	White	White	White	White	White
Male	Male	Male	Male	Male	Male
Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
No	No	No	No	No	No
James I. Boyd, M.D.	James I. Boyd, M.D.	James I. Boyd, M.D.	James I. Boyd, M.D.	James I. Boyd, M.D.	James I. Boyd, M.D.
February 9, 1935	February 9, 1935	February 9, 1935	February 9, 1935	February 9, 1935	February 9, 1935
Prince George's County	Prince George's County	Prince George's County	Prince George's County	Prince George's County	Prince George's County
Clinton	Clinton	Clinton	Clinton	Clinton	Clinton
U. S. A.	U. S. A.	U. S. A.	U. S. A.	U. S. A.	U. S. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02213
Charles

2237

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		d. STREET ADDRESS Post Office Box 201	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last Frazier		4. DATE OF DEATH Month February Day 13 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-32
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Carter		14. MOTHER'S MAIDEN NAME Margaret Nicley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Osby F Frazier		Address Waldorf, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ant pul edema 671X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Profound anemia DUE TO (c) Retained plac. fragments		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/13 1961 , to 2/13 1961 , that (I) (we) last saw the deceased alive on 2/13 1961 , and that death occurred 6:35 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Albert ROTH		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ALBERT ROTH		22d. ADDRESS 5510 Madison-Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2/16/61	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Rockbridge County, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Thomas Co		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
ADDRESS 2901-14th St. NE		25a. REC'D BY REGISTRAR DATE FEB 20 '61	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
2238									
02214									
1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 104 D Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EARL RICHARD GAHLE					4. DATE OF DEATH Month Day Year February 23, 1961.				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 5, 1908		9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Man					10b. KIND OF BUSINESS OR INDUSTRY Television			11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Jahn Galtie					14. MOTHER'S MAIDEN NAME Minerva Utz				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 4200				
17. INFORMANT Mrs Elizabeth Galtie, Same as # 2					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) February 23, 1961.									
ACTUAL SIGNATURE JAMES I. BOYD, M. D.					DATE SIGNED				
EXAMINER'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Feb 25, 1961		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.					24a. REC'D BY REGISTRAR DATE FEB 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

WEST 1911

2283

CERTIFICATE OF DEATH

Prison, County, State of New York

Prison, County, State of New York

Prison, County, State of New York

Prison, County, State of New York

Prison, County, State of New York

Prison, County, State of New York

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Prison, County, State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2239

CERTIFICATE OF DEATH

02215

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia		c. LENGTH OF STAY IN 1b 50 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8600- River View Road S.E.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodore Middle P. Last Gates		4. DATE OF DEATH Month Feb. 18th Day 19 Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17- 1886
9. AGE (In years less birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Phillip H. Gates		14. MOTHER'S MAIDEN NAME Annie Spencer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ernest W. Gates		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420:0 Acute Scurvy to Cirrhosis Liver Chronic Passive Congestion 1 Yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Arterio Sclerotic Heart Disease 11 Yrs		INTERVAL BETWEEN ONSET AND DEATH 1 Yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Coronary Occlusion 1949		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 14, 1961, to 2-18, 1961, that (I) (we) last saw the deceased alive on 2-17, 1961, and that death occurred at 12 P. M. from the causes and on the date stated above.			
22a. SIGNATURE John J. Calarco M.D.		22b. DATE SIGNED 2-18-61	
22c. PHYSICIAN'S NAME (Type) John J. Calarco		22d. ADDRESS 3801- Suitland Road S. E. Wash. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 21st 61	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Piscataway, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE 1661- Good Hope Rd. SE Washington, DC		25a. REC'D BY REGISTRAR DATE FEB 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hous			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02216									
1. PLACE OF DEATH a. COUNTY Prince Georges County					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Pennsylvania				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie					c. LENGTH OF STAY IN TB MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pa RR Spur to Bowie Racetrack					e. STREET ADDRESS Lancaster				
3. NAME OF DECEASED (Type or print) BENJAMIN FRANKLIN GOOD III					4. DATE OF DEATH Month Day Year February 2, 19 61.				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 8, 1924		9. AGE (In years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Home Life Ins. Co of America.		11. BIRTHPLACE (State or foreign country) Lancaster, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME BENJAMIN FRANKLIN GOOD					14. MOTHER'S MAIDEN NAME Florence Trissler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII 184-12-6145		17. INFORMANT Address Florence Trissler, 615 N. Duke St., Lancaster, Pa.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Fracture of the skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in a train that ran off the track							
20c. TIME OF INJURY Month, Day, Year 1:00 p.m. 2/2/ 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Train		20f. (City or town) Jerricho Park P. G.		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED February 2, 1961.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Lancaster		22d. LOCATION (City, town, or country) Lancaster, Pennsylvania		(State)	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,				ADDRESS Riverdale, Maryland.		24a. REC'D BY REGISTRAR FEB 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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100-1000

88-10

James J. Brown, Jr.
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James J. Brown, Jr.

In the year 1900, James J. Brown, Jr.
James J. Brown, Jr.
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02217

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Chester.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Spring City			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS RD #1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pa RR Spur on track to Bowie Racetrack				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BENJAMIN R. GRADY				4. DATE OF DEATH Month February Day 2 Year 19 61.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 9, 1917	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 43 Days 43		IF UNDER 24 HRS. Hours 43 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER				10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME BENJAMIN M. GRADY				14. MOTHER'S MAIDEN NAME SADIE JENKINS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT EDNA S. GRADY RD #1				Address SPRING CITY SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severance of the head at the shoulders DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Passenger of a train that ran off the track			
20c. TIME OF INJURY Month, Day, Year 1:00 p.m. 2/2/ 19 61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Railroad train			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jerricho Park P. G.				20f. (City or town) (County) (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type or print) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED February 2, 1961.			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Parker Ford, Pennsylvania		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Maryland.				24a. REC'D BY REGISTRAR FEB 8 '61			
24b. REGISTRAR'S SIGNATURE Arthur L. Hanks							

MEDICAL CERTIFICATION

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THE STATE
OF NEW YORK

EX-1

James Lewis Jones

James Lewis Jones

James Lewis Jones

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JAMES L. JONES, W.D.

February 2, 1961.

James Lewis Jones

James Lewis Jones

James Lewis Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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2242

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02218

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS Church Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jerry First Middle Last Green		4. DATE OF DEATH Month Day Year Feb. 2 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23. 1904
9. AGE (In years last birthday) 54		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Trainer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerry Green, Sr.		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 152-14-2607	
17. INFORMANT John Boneface - Box 2626, Arlington Sta. 15, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO 433-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vasc. Disease DUE TO Chronic Atrial fibrillation (c) Chronic Atrial fibrillation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days one year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 29 1961 to Feb. 2 1961 , that (I) (we) last saw the deceased alive on Feb. 1 1961 and that death occurred at 1:10 A. M. from the causes and on the date stated above.		22a. SIGNATURE Irvin M. Grassgreen M.D. 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN M.D.		22d. ADDRESS 3101 ARUNDEL RD. MT. LAIMER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-61	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION (City, town, or county) (State) Arbutus, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		25a. REC'D BY REGISTRAR DATE FEB 6 '61	
ADDRESS 802 Madison Avenue		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

REPUBLICAN PARTY

1912

Ballot

James M. Smith

Street

Box 1234

Box 1234

Box 1234

Box 1234

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02219

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 22hrs 27 Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Dupont Heights (Wash. 27 D.C.)	
3. NAME OF DECEASED (Type or print) Baby Boy Greer		4. DATE OF DEATH February 13 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/61 - 9:48PM
9. AGE (In years last birthday) 22		10. IF UNDER 1 YEAR 22 IF UNDER 24 HRS. 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William M Greer		14. MOTHER'S MAIDEN NAME Minnie Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Atelectis es 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Feb 12 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Feb. 13 1961 (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 12 1961 to Feb. 13 1961 , that (I) (we) last saw the deceased alive on Feb 13 1961 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John W Perkins		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr John Perkins M.D.		22d. ADDRESS 5301 Hamilton St, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/28/61	
23c. NAME OF CEMETERY OR CREMATORY Pr. Geo. Gen. Hospital		23d. LOCATION (City, town, or county) (State) Cheverly, P.G. County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE HARRY W. PENN, ADM.		25a. REC'D BY REGISTRAR MAR 7 '61	
25b. REGISTRAR'S SIGNATURE Harry W. Penn		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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2244
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02221

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chewerly				c. LENGTH OF STAY IN 1b 3 Days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Eugene Middle J Last Gundersheimer				4. DATE OF DEATH Month Feb. Day 9 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-10			
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER				10b. KIND OF BUSINESS OR INDUSTRY GREY LINE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME HENRY GUNDERSHEIMER				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 216-073162					
17. INFORMANT HELEN S. GUNDERSHEIMER (AS ABOVE)				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive GI bleeding 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Atherosclerotic Vessels 3 days DUE TO (c) Cirrhosis of liver								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 2/6 19 51 to Feb. 9 19 61 , that (I) (we) last saw the deceased alive on 2/9 19 61 , and that death occurred at 12:30 P.M. of the causes and on the date stated above.									
22a. SIGNATURE Barry Rosenberg				22b. DATE Feb. 10 1961					
22c. PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg, M.D.				22d. ADDRESS 1210 Chillum Manor Road, West Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
BURIAL		2/13/1961		MT. OLIVET CEM.		WASHINGTON, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc. Maryland				ADDRESS Mt. Rainier		25a. REC'D BY REGISTRAR DATE FEB 14 '61			
						25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

Washington, D.C.

October 10, 1934

Mr. J. Edgar Hoover

Director

Washington, D.C.

Re: JAMES EARL RAY

Subject

1-1-34

BUS DRIVER GREY LINE WASHINGTON-TOWNSHIP, U.S.A.

HENRY GUNDERSHIMER UNKNOWN

HELEN S. GUNDERSHIMER (WIFE)

BURIAL 2/13/34 MT OLIVET CEM. WASHINGTON, D.C.

Not a burial, but a cremation

CERTIFICATE OF DEATH

Reg. Dist. No.

02222

2245		Item 14 Film 6282 3/16/61	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT RAINIER, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4609 29th ST. APT 1.		d. STREET ADDRESS 4609 - 29th ST	
3. NAME OF DECEASED (Type or print) ABEL First HABERMAN Middle ABEL Last HABERMAN		4. DATE OF DEATH FEB 7 1961 Month FEB Day 7 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 4, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY CLEANING	11. BIRTHPLACE (State or foreign country) LONDON, ENGLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PHILIP HABERMAN	
14. MOTHER'S MAIDEN NAME Sarah Unterstein		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 578-09-1211		INFORMANT ROTH HABERMAN Address MT RAINIER, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 CORONARY THROMBOSIS DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 YRS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 DAY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 1 , 19 58 , to FEB 7 , 19 61 , that I last saw the deceased alive on FEB 7 , 19 61 , and that death occurred at 10:45 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J N Sugar M.D.		ADDRESS (Street, city or town, state) 4300 RAYMOND DRIVE DATE SIGNED 2/1/61	
PHYSICIAN'S NAME (Type) SAMUEL J N SUGAR		MT RAINIER, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 11, 1961	22c. NAME OF CEMETERY OR CREMATORY Stenwood Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR FEB 14 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2246
CERTIFICATE OF DEATH

Reg. Dist. No. 2223

1. PLACE OF DEATH a. COUNTY <u>QUINTLAND MD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTLAND NURSING HOME</u>		d. STREET ADDRESS <u>2924-WASH PL. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>HAGREEN</u> Last <u>HAGREEN</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 28-75</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES LANGLOS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FERN DELANEY (DAUGHTER)</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>16 years+</u> <u>16 years+</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 15</u> , 19 <u>44</u> , to <u>Feb 18</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>61</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James C. Cawood</u>		ADDRESS (Street, city or town, state) <u>2520 Pennsylvania Ave SE Washington 20 Dc</u>	
PHYSICIAN'S NAME (Type) <u>James C. Cawood, M.D.</u>		DATE SIGNED <u>2/18/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/24/61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Superior, Wisconsin</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Q. Mattingly</u>		ADDRESS <u>131-11th St. S.E.</u>	
24a. RECEIVED BY REGISTRAR <u>FEB 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>BIRTH DATE <i>Jan 15 1876</i></p>		<p>BIRTH PLACE <i>New York City</i></p>	
<p>DECEASED AT <i>Home</i></p>		<p>DATE OF DEATH <i>Dec 10 1921</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>DATE OF BURIAL <i>Dec 12 1921</i></p>		<p>PLACE OF BURIAL <i>St. Paul's Church</i></p>	
<p>NAME OF MINISTER <i>Rev. John Smith</i></p>		<p>NAME OF FUNERAL HOME <i>John Doe & Co.</i></p>	
<p>NAME OF UNDERTAKER <i>John Doe & Co.</i></p>		<p>NAME OF CEMETERY <i>St. Paul's Cemetery</i></p>	
<p>NAME OF INTERVIEWER <i>John Doe</i></p>		<p>NAME OF WITNESS <i>John Doe</i></p>	
<p>NAME OF REGISTRAR <i>John Doe</i></p>		<p>NAME OF CLERK <i>John Doe</i></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2247

02224

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LELAND Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Addie MAY HARDY</u>				4. DATE OF DEATH <u>Feb. 10 1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-76</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>F. Washington Musbaum</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Snyder</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hosp. Record</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4-20-80 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Dis.</u> DUE TO (c) <u>undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 26 1961</u> to <u>Feb 10 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 10 1961</u> , and that death occurred at <u>8:15 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L W Malin</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>L W Malin</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/14/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>M. Walkersville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.C. Barton</u> ADDRESS <u>Walkersville, Md.</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>FEB 15 '61</u>							

CERTIFICATE OF DEATH

1911

Name of Deceased

Age

Sex

Color

Marital Status

Place of Birth

Usual Residence

Occupation

Cause of Death

Time of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

2248

CERTIFICATE OF DEATH

Reg. Dist. No. 02225

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSTVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52H YATTSTVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1620-SHERIDAN STREET</u>				d. STREET ADDRESS <u>1620 SHERIDAN STREET</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>REBECCA BEATRICE HARRIS</u>				4. DATE OF DEATH Month Day Year <u>FEB 8 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 1, 1894</u>	9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>MORRIS ROSENBLUM</u>				14. MOTHER'S MAIDEN NAME <u>ANNA FRIEDMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>083-01-28108</u>		17. INFORMANT <u>DAVID HARRIS</u>		Address <u>HYATTSTVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>3 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>42</u> , to <u>FEB 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>FEB 8</u> , 19 <u>61</u> , and that death occurred at <u>4:24 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u>		M.D. <u>4300 RAYMOND DRIVE</u>		ADDRESS (Street, city or town, state) <u>MT RAINIER, MD.</u>		DATE SIGNED <u>2/8/61</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-10-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY + SONS</u>				ADDRESS <u>3501-14th St. NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Guthrie S. K...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH—BALTIMORE, MD.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2249

02226

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 8210 Sherrill Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Joan Middle D. Last Harvey		4. DATE OF DEATH		Month February Day 13 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/26		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food-Checker-A & P.		10b. KIND OF BUSINESS OR INDUSTRY Food Business		11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -----WHEELER				14. MOTHER'S MAIDEN NAME MAUD WHEELER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT (Husband) Mr. George W. Harvey, Jr.		Address Palmer Pk, Md. 8210-Sherrill St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inlet of truck DUE TO (c) Car on the curv.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/11 1961 , to 2/13 1961 , that (I) (we) last saw the deceased alive on 2/13 1961 , and that death occurred at 7:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dayton O Watkins				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-14-61	
22c. PHYSICIAN'S NAME (Type) DAYTON O WATKINS				22d. ADDRESS 6318 Annapolis Rd Bladensburg Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/16/1961		23c. NAME OF CEMETERY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Hyang Funeral Home				ADDRESS 1300-N. St. N.W. Wash. DC		25a. REC'D BY REGISTRAR DATE FEB 16 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, within 72 hours after death.

CERTIFICATE OF DEATH

2213

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

FOOD-DRINKER-A & J. Food Business

MAUD WHITTIER

(husband)

Mr. George A. Harvey, Jr. 6210 - North 1st St.

Signature of Physician
Signature of Registrar
Date of Death
Place of Death
City
County
State

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2250

02227

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Day 1 1/2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle H. Last Herbert		4. DATE OF DEATH Month Feb Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-04
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.-9.	
13. FATHER'S NAME ERNEST HERBERT		14. MOTHER'S MAIDEN NAME Lillian HARRISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Empyema left chest Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Broncho genic carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1960 to 22 Feb 1961 , that (I) (we) last saw the deceased alive on 22 Feb 1961 , and that death occurred at 6:50 PM from the causes and on the date stated above.			
22a. SIGNATURE H. David Kerr, M.D.		22b. DATE SIGNED 23 Feb 1961	
22c. PHYSICIAN'S NAME (Type) Dr. H. David Kerr		22d. ADDRESS	
23a. BURIAL: Cremation 23b. DATE THEREOF 2/25/61		23c. NAME OF CEMETERY OR CREMATORY Laurel Washington	
23d. LOCATION (City, town, or county) Prince George		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Matthewly Funeral Home		25a. REC'D BY REGISTRAR DATE FEB 28 '61	
ADDRESS 151-11 St. SE		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

— 2401 Hauptbahnhof Prince George

no
ERNEST HERBERT
wife

Lillian HARRISON
D.C.
U.S.D.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02228											
1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine c. LENGTH OF STAY IN 1b 4 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MADGE AUGUSTA HOLE					4. DATE OF DEATH Month February Day 11 Year 19 61.						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1873		9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Retired					10b. KIND OF BUSINESS OR INDUSTRY U.S. Census			11. BIRTHPLACE (State or foreign country) New York			
13. FATHER'S NAME Charles S. Shoemaker					14. MOTHER'S MAIDEN NAME Augusta Cole						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None					16. SOCIAL SECURITY NO. Unknown						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal Charring burns of Body 716.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of house that burned to the ground.						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:05 Feb. 11, 19 61					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home					20f. (City or town) (County) (State) Brandywine, P.G.Cty., Md.						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE JAMES I. BOYD, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 11, 1961.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					22b. DATE THEREOF 2.13.61		22c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		22d. LOCATION (City, town, or country) (State) Washington D C.		
23. FUNERAL DIRECTOR Lee.Funeral Home. 300.4th st N E.Wash.					24a. REC'D BY REGISTRAR FEB 14 '61 DATE					24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

OFFICIAL EXAMINER'S CERTIFICATE OF DEATH

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

Franklin County, Maryland

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2252 CERTIFICATE OF DEATH 02230

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Jackson Last Jackson		4. DATE OF DEATH Month Feb Day 6 Year 19 61	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 April 1922
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hackley		14. MOTHER'S MAIDEN NAME Mable Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George Jackson -Lanham, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Bronchopneumonia 581.0 DUE TO Gastro-intestinal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal Varicosities DUE TO Cirrhosis of the Liver (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours unknown unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 11,50PM from the causes and on the date stated above.			
22a. SIGNATURE Leon L. Gallin MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Leon L. Gallin		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-11-60	23c. NAME OF CEMETERY OR CREMATORY L## Lincoln Memorial	23d. LOCATION (City, town, or county) (State) Suitland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE William J. Ralston		25a. REC'D BY REGISTRAR DATE FEB 14 '61	
25b. REGISTRAR'S SIGNATURE William J. Ralston			

1930

CERTIFICATE OF DEATH

2232

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness.

2253

CERTIFICATE OF DEATH

Reg. Dist. No.

02231

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5406- Shadyside Ave., S.E.		d. STREET ADDRESS 5406- Shadyside Ave., S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle BLANCH Last JENKINS		4. DATE OF DEATH Month Feb. Day 28th Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29- 1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME D?J. Carson		14. MOTHER'S MAIDEN NAME Betty Dollar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Evelyn M. Hollabaugh Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hypertensive Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 15, 1961 to Feb. 28, 1961 , that I last saw the deceased alive on Feb. 28, 1961 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Pecson M.D.		ADDRESS (Street, city or town, state) 7078 Marlboro Pike Wash. 28, D.C. DATE SIGNED 2-28-61	
PHYSICIAN'S NAME (Type) Benjamin S. Pecson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3rd March 61	22c. NAME OF CEMETERY OR CREMATORY Martha's Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Apex, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros ADDRESS 1661- Good Hope Road S.E. Washington, DC.		24a. REC'D BY REGISTRAR DATE MAR 2 61	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL

1925

IN SENATE
January 14, 1925
REPORT
OF THE
ATTORNEY GENERAL
J. P. KANE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1924
ALBANY: J. B. LIPPINCOTT COMPANY
1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2254

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02232

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 29 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Va. b. COUNTY Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. #1 Box 163 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Jenkins				4. DATE OF DEATH Month Day Year Feb. 27 1961																			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-87		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John Henry Jenkins				14. MOTHER'S MAIDEN NAME Mollie ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Hyattsville, Md.											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Mrs. Edith Arnett, 3215 Kenilworth Ave./				17. INFORMANT Hyattsville, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 8 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 30 1961 to Feb. 27 1961 , that (I) (we) last saw the deceased alive on Feb. 27 1961 , and that death occurred at 2 Pm , from the causes and on the date stated above.												22a. SIGNATURE Thomas E. Edison				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Dr. Edison				22d. ADDRESS 1015 Spring St. Silver Spring, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3-5-61				23c. NAME OF CEMETERY OR CREMATORY FAMILY CEMETERY				23d. LOCATION (City, town, or county) (State) COLUMBIA, VIRGINIA											
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Plummer				ADDRESS 3015-12 St. NE				25a. REC'D BY REGISTRAR DATE MAR 3 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

Washington 17 DC

STATE OF NEW YORK
DEPARTMENT OF HEALTH

1933

Volume 1

John Henry Lanning

175, North Avenue, East Rochester, N.Y.

John Henry Lanning

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2255

02253

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Geprge			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 24 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 6202 Lumar Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Johnson				4. DATE OF DEATH Month Feb. Day 26 Year 19 61			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15- 1880	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Johnnie Jenkins				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Julia Gray				Address 1715 Swann St. N W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Congestive Heart Failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Stenosis, severe DUE TO (c) Rheumatic Heart Disease, old. INTERVAL BETWEEN ONSET AND DEATH days unknown Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Substernal thyroid gland,							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan. 27 19 61 to Feb. 20 19 61 , that (I) (we) last saw the deceased alive on Feb. 20 19 61 , and that death occurred at 1:50 P.M. the causes and on the date stated above.							
22a. SIGNATURE Dr. A. Dietz, M.D.				22b. DATE SIGNED 2-21-61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 4314 Gallatin St, Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 2-24-61				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY Church Cemetery				23d. LOCATION (City, town, or county) (State) Oxen Hill, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Plummer				25a. REC'D BY REGISTRAR 3015 12th Street, N.E.			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE FEB 27 '61			



05203

DEPARTMENT OF HEALTH

2252

First Name

Last Name

Address

City

State

Zip

County

Birth Date

Birth Place

Sex

Religion

Marital Status

Education

Age

Color

Height

Weight

Occupation

Income

Home Phone

Business Phone

Mobile Phone

Medical History

Family History

Smoking

Alcohol

Drugs

Notes

Physician's Signature

Date

Physician's Name

Physician's Address

Physician's City

Physician's State

Physician's Zip

Physician's Phone

Physician's Fax

Physician's Email

Physician's License

Physician's Board

Physician's Specialty

Physician's Hospital

Physician's Clinic

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

16
2

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0344733

1. PLACE OF DEATH a. COUNTY Pr Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE NEW YORK b. COUNTY KINGS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BKLYN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pa RR Spur on track to Bowie Race Track		d. STREET ADDRESS 15 Albany St	
3. NAME OF DECEASED (Type or print) Floyd Col		4. DATE OF DEATH February 2, 19 61.	
5. SEX Male		6. COLOR OR RACE Col	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5 MARCH - 1909	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DINING PORTER		10b. KIND OF BUSINESS OR INDUSTRY RR PORTER	
11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HORACE JONES		14. MOTHER'S MAIDEN NAME SYLVESTER SCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT BESSIE HEATHMAN		Address 1603 You ST. N.W. WASHINGTON, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 800X DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest and fractured skull. (c) Crushed chest and fractured skull. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Employee of a train that was in a wreck		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Employee of a train that was in a wreck	
20c. TIME OF INJURY Month, Day, Year 1:00 p.m. 2/2/61		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dinning car		20f. (City or town) (County) (State) Jerricho Park P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED February 2, 1961.	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 2-4-61	
22c. NAME OF CEMETERY OR CREMATORY Shirley		22d. LOCATION (City, town, or country) (State) New York, N.Y.	
23. FUNERAL DIRECTOR W. ERNEST JARVIS		24a. REC'D BY REGISTRAR 1432 You ST. N.W.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAR 13 '61	

FOR THE
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

2230

RECEIVED

NEW YORK

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TO THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2257

CERTIFICATE OF DEATH

02234

1. PLACE OF DEATH a. COUNTY <u>Pr. Geo. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloland Memorial Hosp</u>		d. STREET ADDRESS <u>14300 Emerson St</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>J</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-19-12</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn.</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jones</u>		14. MOTHER'S MAIDEN NAME <u>Martha Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO <u>572.02</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bowel resection - because of</u> DUE TO <u>- Ulcerative Colitis with Melena</u> (c) <u>572.02</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced Marfan's Strumpel's Disease & advanced</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Coroner was notified</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 12</u> 19 <u>61</u> to <u>Feb 20</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb 20</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore Zegarar, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Theodore Zegarar, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		23b. DATE THEREOF <u>2/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Morris Funeral Home</u>		23d. LOCATION (City, town, or county) (State) <u>Johnson City, Tenn.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland</u>	
25a. REC'D BY REGISTRAR <u>DATE FEB 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CENTRICAL OF DEATH

1921



CHIEF OF POLICE

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2258

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02235

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>16 yrs</u>		74	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4509- ELM Wood Road</u>		d. STREET ADDRESS <u>4509- ELM Wood Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH F Joyce</u>		4. DATE OF DEATH Month Day Year <u>Feb 23-nd 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9- 1907</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thaddeus</u>		14. MOTHER'S MARIEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>William F. Joyce</u>	
17. INFORMANT Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>10 yrs.</u> <u>12 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> to <u>Feb 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 16 1961</u> , and that death occurred at <u>6AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank L. Weaver Jr.</u>		22b. ADDRESS <u>Laurel, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER, JR., M.D.</u>		22d. ADDRESS <u>Laurel, Md.</u>	
22e. DATE SIGNED <u>2-23-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 25-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City, town, or county) (State) <u>Landover Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Seminora Brothers</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 24 '61</u>	
ADDRESS <u>1661 Good Hope Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
CENTRAL FILE OF DATA

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CHIEF OF BUREAU

OFFICE OF THE
DIRECTOR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 14 Film G280 2-6-61 et

CERTIFICATE OF DEATH

Reg. Dist. No. **02236**

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville / Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4922 LaSalle Road-Carroll Manor		d. STREET ADDRESS 3043-P-St., N.W. 1922 LaSalle Road	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine C Kelly		4. DATE OF DEATH Month Day Year February 1, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1870
9. AGE (In years last birthday) yrs. 90		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ireland	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Conroy		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT V. Rev. Msgr. John E. Kelly		Address Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 49 , to 2/1 , 19 61 , that I last saw the deceased alive on 2/1 , 19 61 , and that death occurred at 12:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph J. Wallace, M.D.		ADDRESS (Street, city or town, state) 1830 K ST N.W. Wash DC	
PHYSICIAN'S NAME (Type) JOSEPH J. WALLACE, M.D.		DATE SIGNED 2/1/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-61	
22c. NAME OF CEMETERY OR CREMATORY Holy Sepulcher		22d. LOCATION (City, town, or county) (State) Rochester, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE DC	
24a. REC'D BY REGISTRAR FEB 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reverend Mr. Wallace
Baltimore, Maryland

2/11
1230 K 22 N W. WALLACE, D.C.
1230 K 22 N W. WALLACE, D.C.
2/11
1230 K 22 N W. WALLACE, D.C.

TO HOSPITAL OR A Dying PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film G282 3/17/61 mh

2260

02237

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL MANOR		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D.C. f. COUNTY MARYLAND g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYATTSVILLE h. STREET ADDRESS 4205 New Hampshire Ave. 4922 LANSALLE ROAD N.W.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSE M. KEMP		4. DATE OF DEATH 2 1 19 61		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-29-78	
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RETIRED)		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN A. KEMP		14. MOTHER'S MAIDEN NAME ANN IRVIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 718-10-5685		16. SOCIAL SECURITY NO. 718-10-5685		17. INFORMANT CARROLL MANOR RECORDS (SAME AS #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Glomerulonephritis Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 592x		INTERVAL BETWEEN ONSET AND DEATH 5 days 22 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.		20g. (County) D.C.		20h. (State) D.C.	
21. I certify that (I) (this hospital) attended the deceased from 3/30/1959 to 2/1/1961 , that (I) (we) last saw the deceased alive on 1/31/1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Thomas F. Collins M.D.		22b. DATE Feb. 1, 1961		22c. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.	
22d. ADDRESS 322-H. St. N.E. - Washington, D.C.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
23b. DATE THEREOF 2-4-61		23c. NAME OF CEMETERY OR CREMATORY Mt OLIVET CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. ADDRESS 3821 14th. ST. N.W. WASH. D.C.		25. REC'D BY REGISTRAR Feb 6 '61	
25a. REGISTRAR'S SIGNATURE Arthur S. Hines		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1990

Chronic Glomerulonephritis

100-101

22/01/16

1991/12/1

Feb. 1, 1901

THOMAS H. COLLINS, Mayor, Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

2261
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02238

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Woodridge</i>		c. LENGTH OF STAY IN 1b <i>49 North Woodridge</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4510-24th Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Amelia E. Klein</i>		4. DATE OF DEATH Month <i>February</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 4, 1875</i>
9. AGE (In years lost birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>5</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington 10c</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington 10c</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mary Ann Harvey</i>		Address <i>Star Route Laurel Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO <i>cardio-vascular</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hypertension</i> (c) <i>atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1</i> 19 <i>61</i> to <i>Feb 11</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Feb 10</i> 19 <i>61</i> and that death occurred at <i>10:35</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>J. Chester Brady</i>		22b. DATE SIGNED <i>2/11/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. Chester Brady</i>		22d. ADDRESS <i>3524 Ave NW</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/14/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		23d. LOCATION (City, town, or county) (State) <i>Washington 10c</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Seiers Sons Co</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 14 '61</i>	
ADDRESS <i>3605-14 St NW</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

Wash 10c

CERTIFICATE OF DEATH

1910

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Married		Farmer		Heart Disease		Jan 15, 1910		Home		J. Smith		A. Jones	
Place of Birth		Date of Birth		Date of Death		Time of Death		Time of Burial		Place of Burial		Name of Minister		Name of Undertaker		Name of Coroner		Name of Jury		Name of Witnesses	
New York		Jan 1, 1865		Jan 15, 1910		10:00 AM		11:00 AM		Cemetery		Rev. P. Q. R.		S. T. U.		V. W. X.		Y. Z. A.		B. C. D.	
County		Town		Village		City		State		Country		County		Town		Village		City		State	
Albany		Saratoga		Saratoga		Saratoga		New York		United States		Albany		Saratoga		Saratoga		Saratoga		New York	
Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Married		Farmer		Heart Disease		Jan 15, 1910		Home		J. Smith		A. Jones	

CERTIFICATE OF DEATH

Reg. Dist. No.

02239

2262

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>PR. Geo. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>So. Md. Hospital Center.</u>		d. STREET ADDRESS <u>1 RFD # 3 - Box 632</u>	
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>G.</u> Last <u>KNIGHT.</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>#128/94</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West. Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>W. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William R. Meadows</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Robert L. Knight Clinton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CIRCULATORY COLLAPSE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY INSUFFICIENCY 1 HOUR</u> (c) <u>CARCINOMATOSIS GENERALIZED 3 WKS.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIVERTICULOSIS of INTESTINE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 20</u> , 19 <u>60</u> , to <u>FEB 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>FEB 6</u> , 19 <u>61</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred R. Lapin</u> M.D.		ADDRESS (Street, city or town, state) <u>CLINTON, MD</u>	
PHYSICIAN'S NAME (Type) <u>Alfred R. Lapin</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 10 - 61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summons Bros 1661-9d Hays Rd</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE FEB 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2565

1912

10-116 Hospital Center

DECEASED

4-24-12

3-10-12

CO. 1000

SPRINGFIELD

DECEASED

Feb 14

Clinton Mo

Clinton Mo

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
Prince George				Md.		Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Cheverly		5 hrs.		66 E. Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
Prince George General				1 6006 Longfellow Street			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		Milton A.				Kyle	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White				4-14-15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
STEAM OPERATOR		P.E.P.C. D.C		WASHINGTON, D.C		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HOWARD KYLE				PANSY CRAWFORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
YES		WORLD WAR II 577-05-5960		MARGARET G. KYLE		SAMS AS #2	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Occlusion of Right Coronary Artery (c) Coronary Atherosclerotic Ht. Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 5 hrs. unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19-61, to 19-61, that (I) (we) lost the deceased on 2-3-61, 19-61, and that death occurred at 1055 A.M. from the causes on and on the date stated above.							
22a. SIGNATURE Albert Roth, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 4, 1961	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
Albert Roth, M.D.				5510 Madison St. Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		FEB 7, 1961		CEDAR HILL CEM		SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Chambers				ADDRESS RIVERDALE MD		25a. REC'D BY REGISTRAR DATE FEB 9 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(I)



077

2252

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2264

02241

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheltenham d. STREET ADDRESS Post Office e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS PHILIP LA ROQUE		4. DATE OF DEATH Month February Day 10, Year 19 61.					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 20, 1895	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) St. Paul, Minnesota			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Joseph LaRoque			14. MOTHER'S MAIDEN NAME Catherine Elizabeth ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 214-127799		17. INFORMANT Thomas J. LaRoque, Clinton, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42000 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) WALDORF, MD.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		DATE SIGNED February 10, 1961					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-13-61		22c. NAME OF CEMETERY OR CREMATORY ST PAULS			
23. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		22d. LOCATION (City, town, or country) (State) WALDORF, MD.		24a. REC'D BY REGISTRAR FEB 14 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

1912

OFFICE OF THE STATE DEPARTMENT OF HEALTH
BUREAU OF STATISTICS AND RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of ... State of New York

Decedent's Name ...

D.O.B. ...

Residence ...

Place of Death ...

Post Office ...

SEX

MALE

February 10, 1912

Race ...

March 20, 1912

Profession ...

St. Louis, Missouri

Married ...

Deceased ...

Age ...

31-32 yrs

James A. ...

1

January 10, 1912

JAMES A. ...

JOHN ...

ST. LOUIS

...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02242

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>	
c. LENGTH OF STAY IN <u>3 months</u>		d. STREET ADDRESS <u>1 Route #1 Box 70</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 1 Box 70</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie Leak</u>		4. DATE OF DEATH <u>2</u> <u>25</u> <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-92</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ware Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hassee Leak, same as #2</u>	
17. INFORMANT <u>Hassee Leak, same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> (c) <u>Cardiovascular renal disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>2-26-61</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-3-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CARVER MEM. CEM</u>		22d. LOCATION (City, town, or country) (State) <u>BELTSVILLE, MD.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Plummer</u>		ADDRESS <u>301-12th St NE</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Kinn</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

MEDICAL CERTIFICATION

STATE OF TEXAS
COUNTY OF DALLAS
EXAMINER OF DEEDS
1904

100-101
STATE DEPT.

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100-101
STATE DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2266

02243

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6009 LAFAYETTE AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u> d. STREET ADDRESS <u>6009 LAFAYETTE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLARA</u>		First <u>M.</u> Middle <u>LIPPERT</u> Last		4. DATE OF DEATH Month <u>FEB.</u> Day <u>11.</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JUNE 27, 1877</u>		9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RHINEHART COOK</u>			14. MOTHER'S MAIDEN NAME <u>MARY GOODEN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>6009 LAFAYETTE AVE</u> <u>RAYMOND LIPPERT RIVERDALE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 442X DUE TO (b) <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Myo Carditis - Nephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 11, 1957</u> to <u>Feb 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 11, 1961</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Nettles</u> M.D.				22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Nettles</u>				22d. ADDRESS <u>1222 Monroe St NE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>87. Bonaventure Cent. Allegheny N.Y.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u>		ADDRESS <u>Washington D.C.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>1461</u> <u>Arthur E. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1 4 M X 0 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 2267 2267 1 4 M X 0 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2267 2267 1 4 M X 0 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

12244

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Hyattsville (Green Meadows)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6511 20th Ave.</u>				d. STREET ADDRESS <u>16511 20th Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE C. LIVAUDAIS</u>				4. DATE OF DEATH Month Day Year <u>Feb 12 19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1864</u>	
9. AGE (In years lost birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Music</u>			
11. BIRTHPLACE (State or foreign country) <u>Columbia, Louisiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wade H. Hough</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT Address <u>Mrs. Urdine L. Fitzgerald (same as #2)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>generalized arteriosclerosis</u> (b) <u></u> DUE TO <u></u> (c) <u></u>							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>332X</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1942</u> , 19 <u>61</u> , to <u>2/12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/11</u> , 19 <u>61</u> , and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Burns</u> M.D.				DATE SIGNED <u>2/12/61</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. BURNS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 16, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Moreau, Louisiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Walters</u> ADDRESS <u>254 Carroll St NW D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>							

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1890</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>10-25-1960</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>10-26-1960</u></p>		<p>12. Place of registration: <u>NEW YORK</u></p>	
<p>13. Name of informant: <u>JOHN J. SMITH</u></p>		<p>14. Relationship to deceased: <u>Self</u></p>	
<p>15. Address of informant: <u>123 Main St, New York</u></p>		<p>16. Telephone number: <u>123-4567</u></p>	
<p>17. Name of informant: <u>JOHN J. SMITH</u></p>		<p>18. Relationship to deceased: <u>Self</u></p>	
<p>19. Address of informant: <u>123 Main St, New York</u></p>		<p>20. Telephone number: <u>123-4567</u></p>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2268

02245

2268

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 2216 Kearny Street N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle R. Last MacDonald				4. DATE OF DEATH Month 2-14- Day Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH -02 7-17-03	
9. AGE (In years lost birthday) 58 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WRITER				10b. KIND OF BUSINESS OR INDUSTRY FREELANCE			
11. BIRTHPLACE (State or foreign country) SCOTLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME PETER MacDonald				14. MOTHER'S MAIDEN NAME ANNIE MAC-RITCHIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 085-07-6176			
17. INFORMANT EDNA 4 MacDonald 2216 KEARNY ST. NE				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pul empy hri DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis of the DUE TO cor. (c) 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19 to Feb 14 , 1961, that (I) (we) last saw the deceased alive on Feb 14 , 1961, and that death occurred 20:25 PM from the causes and on the date stated above.							
22a. SIGNATURE Leon R. Levitsky M.D.				22b. DATE 2/15/61			
22c. PHYSICIAN'S NAME (Type) Dr. Leon R. Levitsky, M.D.				22d. ADDRESS 3408 Rhode Island Ave. Mt Rainier Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/17/61			
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln				23d. LOCATION (City, town, or county) (State) 3301 Bladenburg N.E. Washington			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				25a. REC'D BY REGISTRAR 5801 Cleveland			
25b. REGISTRAR'S SIGNATURE Online S. Harris				DATE FEB 17 '61			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2269

CERTIFICATE OF DEATH

02246

1. PLACE OF DEATH, a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Prince George's Rest Home, Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial Hospital</i>		d. STREET ADDRESS <i>11012 Montgomery Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Josephine</i> Middle <i>M.</i> Last <i>Maher</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>17</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown 1871</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Maher</i>		14. MOTHER'S MAIDEN NAME <i>Anne Fitzpatrick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>✓</i>	
17. INFORMANT <i>Mrs. Borck</i>		Address <i>11012 Montgomery Rd., Beltsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Anterior wall myocardial infarction</i> DUE TO (c) <i>✓</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility - Old Age</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2-8</i> 19 <i>61</i> to <i>2-17</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>2-17</i> 19 <i>61</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>D.R. Purdie</i>		22b. DATE SIGNED <i>2-17-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>D. R. Purdie</i>		22d. ADDRESS <i>90 Leland Mem. Hosp. Riverdale, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2/21/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Augustine Cem. Elbridge Md.</i>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Courtenay</i>		25a. REC'D BY REGISTRAR <i>✓</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>		DATE <i>FEB 20 '61</i>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

John J. ...
born ...
died ...
cause of death ...
place of death ...
attending physician ...
buried ...

John J. ...
born ...
died ...
cause of death ...
place of death ...
attending physician ...
buried ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only one within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G281 2-20-61 et

CERTIFICATE OF DEATH

Reg. Dist. No. 2277

2270

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 47	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 4100-30 th Street	
3. NAME OF DECEASED (Type or print) First Middle Last Hans G. Matthesius		4. DATE OF DEATH Month Day Year Feb. 7 th , 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1892	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic		10b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone Co.	
11. BIRTHPLACE (State or foreign country) Leipzig, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Matthesius		14. MOTHER'S MAIDEN NAME Johanna — Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Ethel A. Matthesius Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4204 DUE TO Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 mos.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1960, to Feb 7, 1961, that I last saw the deceased alive on Feb 6, 1961, and that death occurred at 10:05 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217/61. DATE SIGNED			
ACTUAL SIGNATURE Earl W. Graef		M.D. 2916 Kirkwood Place	
PHYSICIAN'S NAME (Type) EARL W. GRAEF, M.D.		W. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/61	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.		24a. REC'D BY REGISTRAR ADDRESS Mt. Rainier, Md. DATE FEB 14 1961	
24b. REGISTRAR'S SIGNATURE Arthur E. Hume			

CERTIFICATE OF DEATH

8870

[Faint, mostly illegible text on a death certificate form. The form includes fields for patient information, cause of death, and medical history. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

[Vertical text on the right margin, likely a filing or tracking number, oriented vertically.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2271

CERTIFICATE OF DEATH

02248

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY in lb 22 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5705 AGER ROAD				d. STREET ADDRESS 5705 AGER ROAD			
3. NAME OF DECEASED (Type or print) ELOISE WOOTEN MAY				4. DATE OF DEATH Month FEB. Day 8 Year 19 61			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/80	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 8 Days 19	IF UNDER 24 HRS. Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD WOOTEN				14. MOTHER'S MAIDEN NAME MARY CAROLINE DUFFY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. Oscar W. May, 5705 Ager Road Hyattsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) GENERALIZED ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 7/14 , 19 59 to 2/18 , 19 61 ; that (I) (we) last saw the deceased alive on 2/2 , 19 61 , and that death occurred at 10:45 M., from the causes and on the date stated above.							
22a. SIGNATURE Norman Donat Comeau M.D.				22b. DATE SIGNED 2/8/61			
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU				22d. ADDRESS 3503 PENNY ST MT RAINIER MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/10/61	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town or county) (State) PRINCE GEO. COUNTY, MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zioka INC.				25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2270

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Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text at the bottom of the page, including what appears to be a date "1/1" and other illegible markings.

2272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 1 YR.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 Greenlawn Dr. Hyattsville, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle IGNATIUS Last MCDERMOTT				4. DATE OF DEATH Month FEB Day 15 Year 1961			
5. SEX M	6. COLOR OR RACE WH	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 14, 1887		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TICKER CLERK		10b. KIND OF BUSINESS OR INDUSTRY PENN. R.R.		11. BIRTHPLACE (State or foreign country) PHILADELPHIA PA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NEIL X Hugh McDermott				14. MOTHER'S MAIDEN NAME Elizabeth McDermott (This is correct)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. SON		INFORMANT Address 401 GREENLAWN DR. HYATTSVILLE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS DUE TO (c) GENERALIZED ARTERIO SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 2 DAYS SEVERAL YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERY DISEASE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from OCT. , 1960, to 15 FEB , 1961, that I lost the deceased alive on 15 FEB , 1961, and that death occurred at 3:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis C Mayle Jr				ADDRESS (Street, city or town, state) 8218 WISCONSIN AVE DATE SIGNED 2/15/61			
PHYSICIAN'S NAME (Type) FRANCIS C MAYLE JR				BETHESDA 14 MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home ADDRESS 14th Rainier Md.				24a. REC'D BY REGISTRAR DATE FEB 21 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

ORIGINAL

2555

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02250

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN lb D.O.A d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGE'S GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 3950 Suitland Road Apt #101 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Souder McKimney First Middle Last 4. DATE OF DEATH Feb. 4, 1961 Month Day Year		5. SEX MALE 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 4, 1919 9. AGE (In years last birthday) 41 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry C. McKimney 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) World W.2 Navy 16. SOCIAL SECURITY NO. 578-14-2237 17. INFORMANT Elmer A. Pierce Address 4036 Alabama Ave., S.E. Wash. D.C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Barbiturate poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Depressed & ; Chronic Nephritis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Took twenty (20) Tuina Capsules 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Took twenty (20) Tuina Capsules 20c. TIME OF INJURY Month, Day, Year 11:30 a.m. 2/4/ 1961 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Suitland (County) P.G. (State) Maryland		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/4/61 Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-8-61 22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. 22d. LOCATION (City, town, or country) Arlington Va. (State)		23. FUNERAL DIRECTOR Simmons Bros. ADDRESS 1661- Good Hope Rd SE Wash. 20 D C 24a. REC'D BY REGISTRAR DATE FEB 6 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

2883

THE STATE
OF NEW YORK

IN SENATE

JANUARY

1901

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED

APRIL

1900

AND

WHITE

REPORT

U.S.A.

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED

APRIL

1900

REPORT

AND WHITE REPORT

RECEIVED 3 : CHRONIC

LOOK TWENTY (20) YEARS

11:30 AM

NAME

DATE

1901

JANUARY 1, 1901

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2274

02251

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Loraine Middle McKinstry Last McKinstry		4. DATE OF DEATH Month February Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15, 1893
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME George Fromang		14. MOTHER'S MAIDEN NAME Eda Laubscher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Dr V. L. Fromang Vero Beach Florida.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous lesion 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of uterus. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 17 19 61 to Feb 26 19 61 , that (I) (we) last saw the deceased alive on Feb 26 19 61 , and that death occurred at 7:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE A. Deitz		22b. DATE SIGNED 2-27-61	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS 4314 Gallatin St. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 28, 1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Maryland.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAR 2 '61	

2274

CERTIFICATE OF DEATH

1927

Place of Birth

Age

Sex

Place of Death

Time

Cause

Place of Burial

Date

Signature

Location

Address

City

Time of Death

Signature

Witness

Location

City

Signature

Witness

Place of Burial

NO

Place of Burial

Place of Burial

Place of Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2275 CERTIFICATE OF DEATH 02252											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)						c. LENGTH OF STAY in 1b 1 month and 21 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital						d. STREET ADDRESS 1810 T. St., N. W.					
3. NAME OF DECEASED (Type or print) John - McLeod						4. DATE OF DEATH 2 27 19 61					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> but separated (not legally)		8. DATE OF BIRTH 4/25/1899		9. AGE (in years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY O'Donnells Sea Grill				11. BIRTHPLACE (County & State, or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John McLeod						14. MOTHER'S MAIDEN NAME Mattie ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-16-1661		17. INFORMANT Decedent				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced 002X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Left nephrectomy 1939; partial gastrectomy 1955; diabetes mellitus, mild											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1/6/1961 to 2/27/1961, that (I) (we) last saw the deceased alive on 2/27/1961, and that death occurred at 1:45 P.M., from the causes and on the date stated above.											
22a. SIGNATURE Moe Weiss				M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/27/1961			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-4-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				23d. LOCATION (City, town or county) Suitland			
23e. NAME OF CEMETERY OR CREMATORY 1822-11th St NW Wash DC.				25a. REC'D BY REGISTRAR DATE MAR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank					
FUNERAL DIRECTOR'S SIGNATURE John W. Latney											

2537



James Gordon

John (Jr.)

John (Jr.)

John

John

John

John

John

John

John

John

John

John

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2276 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02253

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVERDALE				c. LENGTH OF STAY IN 1b Dead on arrival			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LELAND MEMORIAL HOSPITAL				d. STREET ADDRESS 1016 Marton Street			
3. NAME OF DECEASED (Type or print) Daniel Lawrence McNabb				4. DATE OF DEATH February 12 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1960	
9. AGE (in years last birthday) 4		10. IF UNDER 1 YEAR 4 Months 17 Days		11. IF UNDER 24 HRS. 17 Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME John Joseph McNabb				14. MOTHER'S MAIDEN NAME JEANNE Jeanne Carre			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT John Joseph McNabb, Same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Feb. 12, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14, 1961		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore Md.	
23. FUNERAL DIRECTOR C. Vernon				ADDRESS 4611 Park Heights Ave.			
24a. REC'D BY REGISTRAR FEB 15 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02254

2277

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>37 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3608-Bunker Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Scott</u> Middle <u>Armed</u> Last <u>Melius</u>		4. DATE OF DEATH <u>Feb. 1st</u> 19 <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22 / 85</u> 75
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Allentown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Martin Luther Melius</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mainie A. Melius, Wife</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC Ht Disease</u> 420.9 DUE TO <u>Severe branched arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paraplegia due to CVA</u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10-15 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u> </u> , to <u>Jan</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon R. Gallin MD</u>		ADDRESS (Street, city or town, state) <u>W. Hg ATTsville, Md.</u> DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>LEON R. GALLIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/4/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalleys Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

CERTIFICATE OF DEATH

1907

[Faint, mostly illegible handwritten text follows, likely containing details of the death certificate such as name, date, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2278

CERTIFICATE OF DEATH

02255

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tracy Middle Alison Last Mennard		4. DATE OF DEATH Month Feb Day 18 Year 1961	
5. SEX Fe.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1961
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Michael Mennard		14. MOTHER'S MAIDEN NAME Nancy Lee Beecher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Hospital record		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mass. post. Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 77ix DUE TO (c) 11 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on Feb. 18 1961 , and that death occurred at 2:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Mary K. L. Sartwell		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Mary K.L. Sartwell		22d. ADDRESS 6811 Riggs Road, Hyattsville, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 24, 1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

CERTIFICATE OF DEATH

1914



1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Name of physician: _____

6. Name of funeral director: _____

7. Name of next of kin: _____

8. Name of informant: _____

9. Name of registrar: _____

10. Name of officiating clergyman: _____

11. Name of undertaker: _____

12. Name of cemetery: _____

13. Name of burial place: _____

14. Name of interment place: _____

15. Name of place of burial: _____

16. Name of place of interment: _____

17. Name of place of burial: _____

18. Name of place of interment: _____

19. Name of place of burial: _____

20. Name of place of interment: _____

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97. Name of place of burial: _____

98. Name of place of interment: _____

99. Name of place of burial: _____

100. Name of place of interment: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2279

02256

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lannd</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1011 Bond Mill Road</u>		d. STREET ADDRESS <u>1011 Bond Mill Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>John</u> Last <u>Miemietz</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29 1916</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Country of Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Miemietz</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Kampa</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>111-111-1111</u>	
17. INFORMANT <u>Robert Marion Miemietz, Lannd Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Cirrhosis of Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Alcoholism</u> DUE TO (c) <u>Chronic Alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> 19 <u>58</u> to <u>2/13</u> 19 <u>61</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>2/13</u> 19 <u>61</u> , and that death occurred at <u>11P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/17/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Crown Point Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Sanderson, Lannd, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 20 61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2280

02257

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>No. Brentwood</u> <u>45</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. Co Hospital</u>				d. STREET ADDRESS <u>4514 Banner St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha Ellen Moore</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15 1885</u>	
9. AGE (In years last birthday) <u>75 7/8</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Fam.</u>		11. BIRTHPLACE (State or foreign country) <u>Bowie Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Blackston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Maude L. Gilbert</u> Address <u>4514 Banner St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>virus infection</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-31</u> 19 <u>61</u> , to <u>2-1</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> 19 <u>61</u> , and that death occurred at <u>2-1</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Leonard Hays</u>				22b. DATE SIGNED <u>2-1-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Henry S. Washington</u>				22d. ADDRESS <u>Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-4-61</u>		23b. DATE THEREOF <u>2-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Brimmy Rd SE. DC</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

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From a letter to the
Commissioner of Health
dated Feb 10 1902
The following is a list of
the names of the persons
who have been
admitted to the
hospital since
the 1st of
January 1902

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Previous Illness		Cause of Admission		Date of Admission		Discharge Date		Remarks	
John Doe		45		M		W		C		M		C		H		N		P		1-15-02		2-10-02		Discharged	
Jane Smith		32		F		W		C		M		C		H		N		P		1-20-02		2-15-02		Discharged	
Robert Brown		58		M		W		C		M		C		H		N		P		2-1-02		2-10-02		Discharged	
Mary White		28		F		W		C		M		C		H		N		P		2-5-02		2-12-02		Discharged	
James Black		65		M		W		C		M		C		H		N		P		2-8-02		2-18-02		Discharged	
Elizabeth Green		42		F		W		C		M		C		H		N		P		2-12-02		2-20-02		Discharged	
William Hall		72		M		W		C		M		C		H		N		P		2-18-02		2-25-02		Discharged	
Sarah King		35		F		W		C		M		C		H		N		P		2-22-02		2-28-02		Discharged	
George Lee		55		M		W		C		M		C		H		N		P		2-25-02		3-1-02		Discharged	
Anna Miller		25		F		W		C		M		C		H		N		P		3-1-02		3-8-02		Discharged	
Charles Wilson		68		M		W		C		M		C		H		N		P		3-5-02		3-12-02		Discharged	
Margaret Young		38		F		W		C		M		C		H		N		P		3-12-02		3-19-02		Discharged	
Thomas Ziegler		78		M		W		C		M		C		H		N		P		3-15-02		3-22-02		Discharged	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02258

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1000 12th St., SE Apt 310	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrude Middle - Last Murphy		4. DATE OF DEATH Month 2 Day 17 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/1/10
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months - Days -	11. IF UNDER 24 HRS. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY D.U.C. Board	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Spriggs		14. MOTHER'S MAIDEN NAME Isabell Tyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No -		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581-1 Acute hepatic decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laennec's cirrhosis of liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/9/1960 to 2/17/1961, that (I) (we) last saw the deceased alive on 2/17/1961, and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss, M. D.		22b. DATE SIGNED 2/17/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/61	
23c. NAME OF CEMETERY OR CREMATORY Spriggs Family Cemetery		23d. LOCATION (City, town, or county) (State) Spottsylvania Co. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Johnson		25a. REC'D BY REGISTRAR FEB 23 '61	
25b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2282
CERTIFICATE OF DEATH

02259
47A-3

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS AFB WASH 25 DC			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON (BOLLING AIR FORCE BASE) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON (BOLLING AIR FORCE BASE) d. STREET ADDRESS 67 WESTOVER AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last GRACE MILLICENT NEWMAN			4. DATE OF DEATH Month Day Year FEBRUARY 21 19 61		
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 NOVEMBER 1876	9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES			13. FATHER'S NAME NOBLE		
14. MOTHER'S MAIDEN NAME BIANCA DUAL			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. HOSPITAL RECORDS			17. INFORMANT HOSPITAL RECORDS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HYPOTENSIVE EPISODE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INTRAVASCULAR THROMBOSIS DUE TO (c) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA AND BRONCHITIS					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 February, 19 61 , to 21 February 19 61 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 21 February 19 61 , and that death occurred at 1210A from the causes and on the date stated above.					
22a. SIGNATURE John F. X. Cline		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 21 February 1961	
22c. PHYSICIAN'S NAME (Type) JOHN F X CLINE, (MD) CAPT USAF MC		22d. ADDRESS USAF HOSPITAL ANDREWS AFB WASHINGTON 25 DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 23 FEB. 1961	23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY	23d. LOCATION (City, town, or county) (State) WASHINGTON D.C.		
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME Inc.		ADDRESS 816 Hsh. NE. WASH DC		25a. REC'D BY REGISTRAR FEB 23 '61	25b. REGISTRAR'S SIGNATURE Anthony S. Kiana

DATE OF DEATH

1.
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A/SME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02260

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGE'S GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO d. STREET ADDRESS BOX #2367 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JEROME MARVIN NEWMAN		4. DATE OF DEATH Month Day Year Feb. 4 1961		9. AGE (In years last birthday) 4 Mos.		IF UNDER 1 YEAR Months Days 4 Mos.		IF UNDER 24 HRS. Hours Min. 4 Mos.	
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1960		11. BIRTHPLACE (State or foreign country) MARYLAND	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE (CHILD)		10b. KIND OF BUSINESS OR INDUSTRY NONE		12. CITIZEN OF WHAT COUNTRY? MARYLAND		13. FATHER'S NAME JAMES HERMAN NEWMAN		14. MOTHER'S MAIDEN NAME ELIZABETH LENA BUTLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. *****		17. INFORMANT JAMES HERMAN NEWMAN		Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 6		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>James I. Boyd</i>		EXAMINER'S NAME (Type) JAMES I. BOYD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				DATE SIGNED 2/4/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or country) Upper Marlboro, Md.		(State)	
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Upper Marlboro,		ADDRESS Md.		24a. REC'D BY REGISTRAR DATE FEB 14 '61		24b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>			

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UNION.

Oct. 1. 1960

ELDER AND RELEASE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2284
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02261

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle R. Last O'Brien				4. DATE OF DEATH Month February Day 4 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-28-14	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) car repairman				10b. KIND OF BUSINESS OR INDUSTRY Washington Terminal - Charleston S. C.			
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Aloysius				14. MOTHER'S MAIDEN NAME Mattie Mae Heatley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Ruth M. O'Brien - Wife				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia, Severe, Upper Lobes DUE TO (b) 490X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) 490X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17 Hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 4, 1961 to Feb. 4, 1961 , that (I) (we) last saw the deceased alive on Feb. 4, 1961 , and that death occurred at 8:00 p.m. , from the causes and on the date stated above.							
22a. SIGNATURE Charles C. Hageage				22b. DATE SIGNED Feb. 4, 1961			
22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D.				22d. ADDRESS 3308 Perry St., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/8/61			
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln				23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.				25a. REC'D BY REGISTRAR DATE FEB 9 '61			
ADDRESS Mt. Rainier, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Huns			

M

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MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02262

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 5421 McBeth Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Wilson O'Brien				4. DATE OF DEATH Month February Day 20 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1914		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 46 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Thomas O'Brien				14. MOTHER'S MAIDEN NAME Elizabeth Rath			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) Yes WW II		16. SOCIAL SECURITY NO. 215-16-6968		17. INFORMANT Emel W. O'Brien, Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Feb. 20, 1961			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/61		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery Co.		22d. LOCATION (City, town, or country) (State) Leesburg, Va.	
23. FUNERAL DIRECTOR F. Gasch's Sons				24a. REC'D BY REGISTRAR Hyattsville, Maryland			
ADDRESS				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			
DATE				FEB 27 '61			

107-10 0251

2285

Prince George's

Prince George's

Prince George's

Geography

B.C.A.

Geography

Prince George's General Hospital

5421 No 6th Street

William

William

O'Brien

February 20, 1914

Male

White

April 9, 1914

18

Olney

Barney

Barney

USA

Joseph Thomas O'Brien

Elizabeth Ruth

Yes

WM 11

215-10-5063 Alford W. O'Brien, same as 2

acute congestive heart failure

hypertensive heart disease

James I. Boyd

Feb. 20, 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2286

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 3, 17, 23 Film 0282 3-2-61 et

02263

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANDREWS AIR FORCE BASE, WASH 25 D.C.		d. STREET ADDRESS 7700 DISTRICT HGTS PRKWY APT 6		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD		First Middle Last (NONE) Frank ODELL		4. DATE OF DEATH Month Day Year FEBRUARY 17 19 61	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 NOVEMBER 1909		9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Inspector		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME FRANK C ODELL		14. MOTHER'S MAIDEN NAME WINNIE ODELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 231-14-3565		17. INFORMANT Mrs. Mary Ruth Odell (Wife) MRS FRANK ODELL (WIFE) Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRAGE DUE TO (b) ACCIDENTAL GUNSHOT WOUND Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE IMMEDIATE					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally shot on Andrews AFB based on investigation by FBI			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 3:30 p. m. Feb 17 19 61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Corp Engr Bldg Andrews Air Force Base, MD.	
20f. (City or town) Andrews Air Force Base, MD.		20g. (County) Prince Georges		20h. (State) MD	
21. I certify that XX (this hospital) received the XX ON February 17 19 61 , that (I) XX last saw the deceased XX on 17 February 61 , and that death occurred at 330P M, from the causes and on the date stated above.					
22a. SIGNATURE THEODORE W RICHEY, Major, USAF MC		22b. DATE 17 February 1961		22c. PHYSICIAN'S NAME (Type) THEODORE W RICHEY Major USAF MC	
22d. ADDRESS USAF Hospital Andrews AFB, Wash 25, DC		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 20 Feb 1961		23c. NAME OF CEMETERY OR CREMATORY Good Hope Cem	
23d. LOCATION (City, town, or county) Hickory, Va -		23e. REC'D BY REGISTRAR Lee Funeral Home 300-4th St. NW Wash DC			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. NW Wash DC		24a. ADDRESS 300-4th St. NW Wash DC		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

X

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2287
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02264

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 65			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 5400 Powatan St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First George Middle Oliveri Last Oliveri		4. DATE OF DEATH		Month Feb. Day 13 Year 1961	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1898	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Oliveri				14. MOTHER'S MAIDEN NAME Frances Di Marzo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 230-09-7237		17. INFORMANT Wanda W. Oliveri		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Occlusion of rt. coronary artery - Coronary Arteriosclerotic Ht, disease DUE TO artery - Coronary Arteriosclerotic Ht, disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Ca. with metastases DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH - 30 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thoracotomy, exploratory, performed 2/13/61 (4 hours before death)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10 19 61 , to Feb 13 19 61 , that (I) (we) last saw the deceased alive on Feb. 13 19 61 , and that death occurred at 3:20 P.M. The causes and on the date stated above.							
22a. SIGNATURE Roy G. Klepser MD				22b. DATE SIGNED 2/14/61			
22c. PHYSICIAN'S NAME (Type) Roy G. Klepser				22d. ADDRESS 1835 Eye Street, N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W W Chamber CO. Riverdale, Md				25a. REC'D BY REGISTRAR DATE FEB 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

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2283

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02265

1. PLACE OF DEATH e. COUNTY		PRINCE GEORGE'S MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
CHEVERLY			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
PRINCE GEORGE'S GENERAL HOSPITAL			
3. NAME OF DECEASED (Type or print)		First Middle Last	
KENNETH WILLIAM ORNOLD			
5. SEX		6. COLOR OR RACE	
MALE		WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 1, 1915	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Cab Driver		Transportation	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Harry Vernon Omold		Emma Colgan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
W.W. Yes WW II		199-03-9652	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		17. INFORMANT Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure		Mrs Edna Omold 5723, 64th Pl., East Pines, Md.	
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis, Arteriosclerotic heart disease			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
JAMES I. BOYD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Feb. 8, 1961	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Arlington National Cemetery		Arlington, Virginia	
23. FUNERAL DIRECTOR		24b. REC'D BY REGISTRAR	
W. W. CHAMBERS CO., Riverdale, Md.		DATE FEB 8 '61	
		24c. REGISTRAR'S SIGNATURE	
		Arthur S. Kraus	

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PRISON RECORDS

CHARTER

PRISON RECORDS CHARTER

RECORDS

RECORDS

RECORDS

Dep. Prisoner

Prison Prisoner

Prison Prisoner

Prison Prisoner

Prison Prisoner

Prison Prisoner

JAMES I. BOND

Prison Prisoner

2289

UNITED STATES DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02266

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last Parke				4. DATE OF DEATH Month Feb. Day 8 Year 19 61			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10, 1894		9. AGE (In years and birth day) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor of Tourist Home Elk Garden, W. Va.				10b. KIND OF BUSINESS OR INDUSTRY Elk Garden, W. Va.		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME Brown Anna Strothen				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?			
16. SOCIAL SECURITY NO. 578-48-5895				17. INFORMANT John T. Parke Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary carcinoma of sigmoid colon DUE TO (c) 18 mths				INTERVAL BETWEEN ONSET AND DEATH 17 mths			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan 25, 19 61 to Feb 8, 19 61 , that (I) (we) last saw the deceased alive on Feb. 8, 19 61 , and that death occurred at 3 P M, from the causes and on the date stated above.							
22a. SIGNATURE George H. McLain				22b. DATE SIGNED Feb 8, 19 61		22c. PHYSICIAN'S NAME (Type) George Henry McLain	
22d. ADDRESS 1746 K Street, N.W.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kalley's Funeral Home, Inc.				25a. RECEIVED BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hance	

CERTIFICATE OF DEATH

2288

1907

1844

Proprietor of Joint Hotel
Green Green Hotel

218 W. 10th

2/11/01
J. H. Green
J. H. Green
J. H. Green

CERTIFICATE OF DEATH

Reg. Dist. 2267

2290

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 2 Box 123 E Laurel</u>		c. LENGTH OF STAY IN 1b <u>10 yrs -</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 2 Box 123 E</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Irene</u> Last <u>Pratt</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep 13 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilson A. Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Elisabeth B Sleasman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Warsaw, Va</u>	
17. WILLIAM T. BOWEN RT. 1 Box 113			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-19</u> , 19 <u>61</u> , to <u>2-5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-3</u> , 19 <u>61</u> , and that death occurred at <u>12:00</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2-5-61 DATE SIGNED</u> ACTUAL SIGNATURE <u>Charles House</u> M.D. <u>4404 Queensbury Rd Riverdale Md.</u> PHYSICIAN'S NAME (Type) <u>Charles House</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/8/61</u>	<u>Methodist Cemetery</u>	<u>Olemit Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Sanderson, Laurel, Md</u>		24a. RECEIVED BY REGISTRAR DATE <u>FEB 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Signature of physician
8. Signature of registrar
9. Signature of coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
2291					CERTIFICATE OF DEATH					02268				
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George									
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital					d. STREET ADDRESS 708 60th Place					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Lillian Middle Price Last Price					4. DATE OF DEATH Month February Day 26 Year 1961									
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29 1902		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Norristown, Pa.				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME Hugh T. Williams					14. MOTHER'S MAIDEN NAME Nettie Williams				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes, give war or dates of service)					17. INFORMANT Hugh C. Barnes Address 4822 10th St., N.E.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 560.2 DUE TO Post operative Abdominal Hernia Repair Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 Days (c) 6 Days										INTERVAL BETWEEN ONSET AND DEATH 15 Min				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work					20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					20g. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Feb 17 19 61 , to Feb 26 19 61 , that (I) (we) last saw the deceased alive on Feb 26 19 61 , and that death occurred at 6:15 AM from the causes and on the date stated above.														
22a. SIGNATURE Thomas G. Edison M.D.					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Thomas G. Edison, M.D.					22d. ADDRESS 1015 Spring St. Silver Spring, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 3-2-61					23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				
23d. LOCATION (City, town, or county) (State) Maryland					23e. REC'D BY REGISTRAR DATE MAR 1 '61					23f. REGISTRAR'S SIGNATURE Arthur S. Thomas				

CERTIFICATE OF DEATH

1950



1. Name of deceased: John Doe
2. Sex: Male
3. Race: White
4. Date of birth: Jan 1, 1900
5. Place of birth: New York, N.Y.
6. Date of death: Dec 31, 1950
7. Place of death: New York, N.Y.
8. Cause of death: Heart disease
9. Manner of death: Natural
10. Signature of physician: John Doe
11. Signature of registrar: John Doe
12. Signature of informant: John Doe

DO NOT WRITE IN THESE SPACES

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2292 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02269

1. PLACE OF DEATH a. COUNTY Prince Georges County				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Box #64 Huntsville Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GREGORY				4. DATE OF DEATH Month Day Year February 10, 19 61.							
5. SEX MA LE		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1960		9. AGE (In years last birthday) yrs. 8		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY Child				11. BIRTHPLACE (State or foreign country) Cheverly, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Landon Parker				14. MOTHER'S MAIDEN NAME Edith Queen							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Edith Queen		Address Box #64, Huntsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MMMX Meningitis, H. Influenzae DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				M.D. JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) February 10, 1961.				DATE SIGNED			
22a. BURIAL, CREMATION, or REMOVAL (Specify) 2-15-61 Lincoln Memorial, Suitland, Md.				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY			
22d. LOCATION (City, town, or country) Md.				22e. REC'D BY REGISTRAR FEB 15 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			
23. FUNERAL DIRECTOR H.S. Washington 4925-Deane Ave, NE				ADDRESS				24a. REC'D BY REGISTRAR			

MEDICAL CERTIFICATION

100-100000

I

100-100000

James Earl Ray
Huntville
Box 100, Huntville, AL

James Earl Ray
Huntville
Box 100, Huntville, AL

James Earl Ray
Huntville
Box 100, Huntville, AL

James Earl Ray
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Box 100, Huntville, AL

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James Earl Ray
Huntville
Box 100, Huntville, AL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2293

CERTIFICATE OF DEATH

Reg. Dist. No. 02270

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1518 Chestnut Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard Lee Reum		4. DATE OF DEATH Month Feb. Day 2, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1879
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Reum		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Martha Reum Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease & Severe Arthritis - Extreme		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 11/31 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , to 2/2 , 19 61 , that I last saw the deceased alive on 1/31 , 19 61 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) RD Bowie Md DATE SIGNED 2/2/61			
ACTUAL SIGNATURE H. James Kurtz		M.D. RFD Bowie Md	
PHYSICIAN'S NAME (Type) H. James OKurtz		R F D Bowie Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/61	22c. NAME OF CEMETERY OR CANONARY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR FEB 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2294

CERTIFICATE OF DEATH

02271

1. PLACE OF DEATH o. COUNTY		PRINCE GEORGE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Riverdale		17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Leland Memorial Hospital		Allens Cabin #4	
3. NAME OF DECEASED (Type or print)		First Middle Last	
Richard Nilda Mac		Richard	
4. DATE OF DEATH		Month Day Year	
		Feb 6 1961	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Fe	W		Aug 7, 1919
10a. USUAL OCCUPATION (Give kind of work done during mst of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Same	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Shardswood		Sarah Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
no		Hospital Record-	
17. INFORMANT Address			
Hospital Record-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 yrs whiteterm	
PREMIA HYPERTENSION CHRONIC GLOMERULAR NEPHROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 20 1961, to Feb 6 1961, that (I) (we) last saw the deceased alive on Feb 6 1961, and that death occurred at 7:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE L W Malin M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L W Malin MD		22b. DATE SIGNED	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		2/9/61	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Fort Lincoln Cem		Colman Manor Md	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Herbert J. Fordson		Laurel Md	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE FEB 14 '61		Arthur J. H.	

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

1894

1894

1894

1



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

2295

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02272

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB Dead on arrival		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		42	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 2811 Crest Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Watts Richardson				4. DATE OF DEATH February 18, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 15, 1921	
9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Building Supply		11. BIRTHPLACE (State or foreign country) West Virginia	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Building Supply		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Watts Richardson				14. MOTHER'S MAIDEN NAME Nancy K. Jarrett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Virginia Richardson, same as " 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED February 18, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR FEB 20 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTE.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2296

03485

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 35 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital				d. STREET ADDRESS Ingewood Farms		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen First Briscoe Middle Roberts Last				4. DATE OF DEATH Feb Month 15 Day 1961 Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1894	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HRS. Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during usual life, even if retired) Manager of own Farm			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Lindin Briscoe				14. MOTHER'S MAIDEN NAME Josephine Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record Address -Same as Item 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 13, 1961 to Feb 15, 1961 , that (I) (we) last saw the deceased alive on Feb 15, 1961 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Robert McCeney				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Leland Memorial Hospital Riverdale, Md.		22b. DATE SIGNED 2/15/61	
22c. PHYSICIAN'S NAME (Type) Robert McCeney, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/61		23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery		23d. LOCATION (City, town, or county) (State) Collington, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home - Upper Marlboro, Md.				25a. REC'D BY REGISTRAR MAR 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 8, 9 will be 282 3-13-61 et 02273											
1. PLACE OF DEATH a. COUNTY Prince Georges County				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince Georges			
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel				d. STREET ADDRESS 619 8th Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT				First EDWARD				Middle ROBINSON			
Last ROBINSON				4. DATE OF DEATH February 11, 19 61.				Month February 11,			
5. SEX Male				6. COLOR OR RACE Negro				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH June 17, 1904				9. AGE (in years last birthday) 56 5/8			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Retired				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Cecil County, Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George Robinson				14. MOTHER'S MAIDEN NAME Caroline Robinson ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II				17. INFORMANT Mrs. Ellen Irene Robinson,			
Address 619 8th Street, Laurel, Maryland.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4 20.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Laurel				20g. (County) Prince Georges				20h. (State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED February 11, 1961.			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2-15-61				22c. NAME OF CEMETERY OR CREMATORY National			
22d. LOCATION (City, town, or country) Baltimore, Md.				22e. REC'D BY REGISTRAR Robert L. Snowden				22f. REGISTRAR'S SIGNATURE Robert L. Snowden			
23. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.				24. REC'D BY REGISTRAR FEB 15 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

THE STATE
DEPARTMENT

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

George Robinson
Laborer - Medical Examination
Male
Born [illegible]
June 17, 1904
February 11, 1951
619 8th Street,
Detroit, Michigan



February 11, 1951

2298

CERTIFICATE OF DEATH

Reg. Dist. No. 02274

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> 48	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>4205-29th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Fred S. Roland</u>		4. DATE OF DEATH <u>Feb. 8</u> 19 <u>61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Yard</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Henry Roland</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Cannon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Informant</u>		17. ADDRESS <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>15 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>52</u> , to <u>Feb 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>61</u> , and that death occurred at <u>Mt. Rainier</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon L. Gallin</u>		ADDRESS (Street, city or town, state) <u>7206 Coleville Rd</u> DATE SIGNED <u>2/10/61</u>	
PHYSICIAN'S NAME (Type) <u>LEON L. GALLIN</u>		W. Hyattsville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 11/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

5298

[Faint, mostly illegible handwritten text follows, likely containing details of the deceased and the circumstances of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20 Film 281 2-28-61										
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
2299										
CERTIFICATE OF DEATH										
02275										
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlow Heights 18					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital					d. STREET ADDRESS 5924 28th Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Marie First G Middle Russell Last					4. DATE OF DEATH Month Feb. 5 Day Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-91		9. AGE (In years and birthday) yrs. 89		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Moore					14. MOTHER'S MAIDEN NAME Anna Kelly					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT William Russell (Same as # 2) Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 904.0 DUE TO Fracture of Left Humerus and Left Femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 24 hours		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell at home								
20c. TIME OF INJURY Month, Day, Year Hour 6:20 p.m. Jan. 31 1961		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) in home		20f. (City or town) Marlow Hgts.		(County) P.G.		
						(State) Md.				
21. I certify that (I) (this hospital) attended the deceased from Feb. 2 1961 to Feb. 5 1961, that (I) (we) last saw the deceased alive on Feb. 3 1961, and that death occurred at 11:50 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Wm. P. Holbrook					22b. DATE SIGNED Feb. 6. 1961					
22c. PHYSICIAN'S NAME (Type) Dr. William Holbrook, M.D.					22d. ADDRESS 4500 College Ave. College Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/8/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town, or county) Arlington, Va.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS 4739 Balt. Ave. Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1933

CONFIDENTIAL

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2300 CERTIFICATE OF DEATH 02277										
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kent Village c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kent Village d. STREET ADDRESS 7343 Hawthorne st. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Janice Anne Schlosser					4. DATE OF DEATH Month Day Year Feb 7 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 18, 1961		9. AGE (In years last birthday) yrs. 20		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Leonard Schlosser					14. MOTHER'S MAIDEN NAME Eleanor Hitt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Mrs Jeannette Nash Address 7343 Hawthorne S t,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 Hydrocephalus								INTERVAL BETWEEN ONSET AND DEATH 1 day - since birth since birth		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 18 Jan 1961, to 7 Feb 1961, that (I) (we) last saw the deceased alive on 7 Feb 1961, and that death occurred at 9 AM, from the causes and on the date stated above.										
22a. SIGNATURE Thomas G. Maloney M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7 Feb 61			
22c. PHYSICIAN'S NAME (Type) THOMAS G. MALONEY					22d. ADDRESS 4814-71st Ave. LINDOVER HILLS MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-8-61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem,		23d. LOCATION (City, town or county) Colmor Manor, Md.				
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th Street N.E.					ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2000

Prince George

Kent Village

Marshall

Kent Village

VXN, Harrison St.

18 Feb

Jan 18, 1961

D.C.

Richard Hitt

and Leonard's Wash 7343 Harrison St

Leahurst State Schismen

1

Colony, W.C.

Ev. Lincoln Co.

2-2-61

See Funeral Home 300-4th Street N.E.

121001

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
2301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
02278														
1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pa RR Spur on Track to Bowie Racetrack					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 534 Terrace Road d. STREET ADDRESS 534 Terrace Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) ROBERT B. SELDOMRIDGE					4. DATE OF DEATH Month February Day 2 Year 19 61.									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1892		9. AGE (in years last birthday) yrs. 68						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender Ret.					10b. KIND OF BUSINESS OR INDUSTRY Bars					11. BIRTHPLACE (State or foreign country) Lancaster, Pennsylvania				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Robert C. Seldomridge					14. MOTHER'S MAIDEN NAME Harriet Sample				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown					16. SOCIAL SECURITY NO. 167-14-6427					17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 801X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest, multiple compound fractures of the legs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in a train that was in a wreck					20c. TIME OF INJURY Month, Day, Year 1:00 p.m. 2/2/ 1961				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Train					20f. (City or town) (County) (State) Jerricho Park P. G. Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) February 2, 1961				
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.					22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Feb. 6, 1961				
22c. NAME OF CEMETERY OR CREMATORY Lancaster					22d. LOCATION (City, town, or county) (State) Lancaster, Pennsylvania					23. FUNERAL DIRECTOR ADDRESS W. W. CHAMBERS CO., Riverdale, Maryland.				
24a. REC'D BY REGISTRAR DA FEB 8 '61					24b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

FOR STATE
DEPT. FILE

2304-107

EXAMINER'S CERTIFICATE OF DEATH

Pennsylvania

Prince Georges County

Imperial

Prince Georges County

274 Prince Road

274 Prince Road on track to Prince Georges

SHIRAZ

1

1000

02

July 30, 1961

White

Male

Lebanon, Pennsylvania U.S.A.

1st London, Eng.

British Sample

Robert J. Seligman

1

107-1-8027

Unknown

Two rings and brooch

Gravestone chest, multiple compound fractures of the legs

Passenger in a train that ran in a track

Lebanon Park P.O. Md.

at train

1:00 PM

February 2, 1961

JAMES J. ROY, M.D.

Lebanon, Pennsylvania

W. J. CHAMBERS CO., Lancaster, Pa.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G282 3-1-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02279

2302

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4825-BARRYMORE DRIVE, OXON HILL</u>		d. STREET ADDRESS <u>4825-BARRYMORE DRIVE OXON HILL</u>	
3. NAME OF DECEASED (Type or print) <u>MARY ANDERSON SHALLCROSS</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23-1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES WOMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WHEELING, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. G.</u>	
13. FATHER'S NAME <u>Henry Clay Shallcross</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Shallcross (maiden name)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-07-0739</u>	
17. INFORMANT <u>KATHERINE A. SWEENEY</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease & congested heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/14/61</u> , 19 <u>61</u> , to <u>2/21/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb. 20</u> , 19 <u>61</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>101 ANDREY LANE</u> DATE SIGNED <u>2/21/61</u>			
ACTUAL SIGNATURE <u>Herbert Wisotsky</u> M.D.		PHYSICIAN'S NAME (Type) <u>HERBERT WISOTSKY</u> OXON HILL MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/24/61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. G. Mattingly</u>		ADDRESS <u>131-11th St. S.E. Washington D.C.</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2303

Item 8 PLUM G201 2/23/61 mn

CERTIFICATE OF DEATH

02280

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Randolph	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS Farmland	
3. NAME OF DECEASED (Type or print) Harriett Emma Shank		4. DATE OF DEATH Feb 15 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Dec. 1888
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 15 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School teacher	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Rev John H Mc Arthur		14. MOTHER'S MAIDEN NAME ? Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Martha L Cook		Address Seabrook Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Maxine positive Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1957 to 2/15 1961 , that (I) (we) last saw the deceased alive on 2/15 1961 , and that death occurred at 1.00 AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. F. Musser		22b. DATE SIGNED 2/16/61	
22c. PHYSICIAN'S NAME (Type) Dr. F. Musser M.D.		22d. ADDRESS 4410 74th Avenue Bellemunde, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		23b. DATE THEREOF 2/16/61	
23c. NAME OF CEMETERY OR CREMATORY Farmland		23d. LOCATION (City, town, or county) (State) Indiana	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR FEB 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

2303

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2304 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02281

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park 7 years		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 54 Takoma Park		d. STREET ADDRESS 1117 Kingwood Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1117 Kingwood Drive				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur Shapiro				4. DATE OF DEATH Feb 7 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney				10b. KIND OF BUSINESS OR INDUSTRY Patent			
11. BIRTHPLACE (State or foreign country) Russia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Morris Shapiro				14. MOTHER'S MAIDEN NAME Rose Aeltzer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 218-38-8566			
17. INFORMANT Address 1608 Park Ave. N. D. Feldman							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion (b) Conditions, if any, which gave rise to immediate cause } DUE TO Cardiovascular renal disease (c) (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 2-4-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 6 - 1961		22c. NAME OF CEMETERY OR CREMATORY B'NAI ISRAEL CEMETERY - OXON HILL - MD		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR ADDRESS B. DANZANSKY, & SONS - 3501-14th ST NW				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	
				DATE FEB 7 '61			

MEDICAL CERTIFICATION

1000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2305 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02282											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie						c. LENGTH OF STAY IN 1b Transient					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bowie Race Track						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Joseph Simon						4. DATE OF DEATH February 20, 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 1909		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Army				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jim Simon				14. MOTHER'S MAIDEN NAME Mary				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 178-07-1343				17. INFORMANT U. S. Army Records, Walter Reed			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute congestive heart failure											
DUE TO (b) Coronary infarction., arteriosclerotic heart disease											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Autopsy performed at Walter Reed											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						DATE SIGNED Feb. 20, 1961					
EXAMINER'S NAME (Type) James I. Boyd						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF FEB. 24, 1961		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State) SCOTSDALE PA.	
23. FUNERAL DIRECTOR						ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Riverside Funeral Home, Inc. 816 H St., N.E., Wash. DC								DATE FEB 23 '61		Anthony S. Harris	



Memo

Director

The Bureau

Re: Summary

100-7-1000

Letter

Feb. 1, 1908

Pennsylvania

Simon

James Joseph

James Joseph

James

James

James

100-7-1000

Feb. 1, 1908

U. S. Army, New York

Route can give help follow

Summary information, extended to the next day

Antony performed at after lunch

Feb. 22, 1908

James I. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2306
CERTIFICATE OF DEATH

02283

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 600 Farragut St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lena - Small		4. DATE OF DEATH Month Day Year 2 19 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1884
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-- unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip E. Hart		14. MOTHER'S MAIDEN NAME Ella Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and arteriosclerotic cardiovascular disease; volvulus, sigmoid, improved; colostomy 2/4/61			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/26 3:15 PM to 2/19/1961, that (I) (we) last saw the deceased alive on 2/19 1961, and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 2/19/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Removal		23b. DATE THEREOF 2/20/61	
23c. NAME OF CEMETERY OR CREMATORY OAKHILL CEMETERY		23d. LOCATION (City, town or county) (State) FREDERICKSBURG, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE M. D. Quinn		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2106



PLATE 10000

PLATE 10000

PLATE 10000

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PLATE 10000

PLATE 10000

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PLATE 10000

PLATE 10000

PLATE 10000

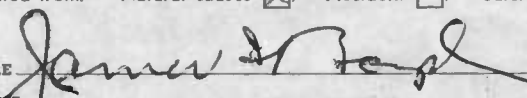
PLATE 10000

PLATE 10000

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02284									
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 1 Route #1, Box 3				
3. NAME OF DECEASED (Type or print) First Middle Last BREND A MARIE SMITH					4. DATE OF DEATH Month Day Year February 26, 19 61.				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 9, 1961		9. AGE (In years last birthday) yrs. 1 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond L. Smith					14. MOTHER'S MAIDEN NAME Margaret A. Jones				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Margaret A. Smith, Same as # 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS AND SEPTICEMIA 756.2 DUE TO (b) INTESTINAL OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CONGENITAL MECAOLON									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE 					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED February 26, 1961.				
22a. BURIAL CREMATION, REMOVAL (Specify)			22b. DATE THEREOF 1-28-61		22c. NAME OF CEMETERY OR CREMATORY Holy Family		22d. LOCATION (City, town, or country) (State) Woodman Md		
23. FUNERAL DIRECTOR Henry S Washington + Son 4923 Neane Ave 75					24a. REC'D BY REGISTRAR DATE FEB 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

2077277XV4

1901



RECEIVED

2003

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Place of death	Private residence
County	Jefferson
City	St. Louis
Place of death	Private residence
County	Jefferson
City	St. Louis
Sex	Male
Age	25 years
Occupation	Student
Signature	James I. Smith
Signature	James I. Smith

1901

JAMES I. SMITH, M.D.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02285

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington Cty.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 24 1/2 Franklin Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH RICHARD SMITH				4. DATE OF DEATH February 26, 1961.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 30, 1908	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY May's Hardware		11. BIRTHPLACE (State or foreign country) Funkstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hiram L Smith				14. MOTHER'S MAIDEN NAME Margaret L Sly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-5027		17. INFORMANT 246 Fredrick St. Marvin W. Smith Hagerstown			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTERY THROMBOSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED February 26, 1961.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/61		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery Hagerstown Md.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR W. J. Hornum Hagerstown Md.				24a. RECORD IN REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MAR 1 '61

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Prince George County

Montgomery

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Montgomery

Leland Medical Hospital

24 Franklin Street

JOHN RICHARD

February 20, 1901

24 Franklin Street

Inspector

Montgomery

March 1, 1901

Montgomery

24 Franklin Street

24 Franklin Street

February 20, 1901

March 1, 1901

3/1/01
The County of Prince George
Montgomery

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2309

CERTIFICATE OF DEATH

02286

Item 1 Film G280 2-6-61 et

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Columbia Park			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Robert Middle Vinton Last S peiden Sr			4. DATE OF DEATH Month Feb. Day 1 Year 1961		
5. SEX Ma le		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/29/1906		9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Building		
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Robert V. S peiden			14. MOTHER'S MAIDEN NAME Mammie England		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs Helen Speiden			Address Landover Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction, Recent 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial Insufficiency DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1/15, 1961, to 2/1, 1961, that (I) (we) last saw the deceased alive on 1/29, 1961, and that death occurred at 2:30 p.m., from the causes and on the date stated above.					
22a. SIGNATURE Barry Rosenberg			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Barry Rosenberg			22d. ADDRESS 5102 Annapolis Rd. Bladensburg, Md.		
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 2-4-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION (City, town or county) Suitland Md.		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home			ADDRESS 300 4th. st. N. E. Washington, 2, D. C.		
25a. REC'D BY REGISTRAR FEB 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2000

Prince George

W. Allen

Prince George

Landover

Robert

Winton

S. Seiden

I. E.

White

S/29/1908

Washington, D.C.

Bolton

Carpenter

Robert V. S. Seiden

W. Allen

Landover

Handwritten signature

2-1-51

Coast Hill

2012 and 2013

Lee Funeral Home

300 4th St. N. E.

Washington, D. C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02287

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE'S GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 CHEVERLY d. STREET ADDRESS 15729 LOCKWOOD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLAIR First Middle Last Doug/ASSPITLER		4. DATE OF DEATH FEB 1 1961 Month Day Year			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARAGE, OWNER		10b. KIND OF BUSINESS OR INDUSTRY AUTO REPAIR		8. DATE OF BIRTH DEC 31, 1894 9. AGE (In years last birthday) 66 yrs.	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. YES		17. INFORMANT MRS. DORIS S. FARR Address 6804 99th AVE. SEABROOK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Coronary arterial heart disease (c) Left Bundle Branch Block PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. Boyd Address (Street, city, town, or county) 2-1-61 DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-4-61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or country) (State) Suitland Md.					
23. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE FEB 3 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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See "United States"
1911-1912

United States

United States

Washington D.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2311

02288

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier Md 47</u> d. STREET ADDRESS <u>3210 - Otis St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>S.</u> Last <u>SWANN</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1961</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan. 6/15</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Lebanon Church, Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Coffelt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Corbett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Charles B. Wilcox, Sr.</u> Address <u>above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolus</u> 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Interochontic Fracture Left Hip</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Hypertensive Cardiovascular Disease, 2. Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in bathroom fracturing left hip</u>		20c. TIME OF INJURY Month, Day, Year <u>11</u> <u>am</u> <u>2-24</u> <u>1961</u>					
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Mt. Rainier Prince Georges Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 24</u> <u>1961</u> , to <u>Feb. 28</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 28</u> <u>1961</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Waldo B. Moyers</u>		22b. DATE SIGNED <u>2-28-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u>			
22d. ADDRESS <u>3503 Perry St. Mt. Rainier Md.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedarwood Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Edinburg, Virginia</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home</u> ADDRESS <u>Mt. Rainier Md.</u>					
25a. REC'D BY REGISTRAR <u>DATE MAR 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					

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MEDICAL CERTIFICATION

235

21-5-59

CERTIFICATE OF DEATH

Reg. Dist. No.

02290

2312

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7641 Kirby Road		d. STREET ADDRESS 7641 Kirby Road	
3. NAME OF DECEASED (Type or print) GERTRUDE BERTHA THOMAS		4. DATE OF DEATH FEB. 25 1961	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 3rd 1908
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR 2 Months 2 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) CLINTON, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK GREEN		14. MOTHER'S MAIDEN NAME ESTELLA JACKSON.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-32-1007	
17. INFORMANT JOHN R. THOMAS Address 7641 Kirby Road		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL BRONCHOPNEUMONIA DUE TO 161X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. GENERALIZED CARCINOMATOSIS DUE TO SQUAMOUS CELL CARCINOMA OF LARYNX. INTERVAL BETWEEN ONSET AND DEATH 2 1/2 DAYS 9 MOS. 21 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year NONE 19 NONE		20d. INJURY OCCURRED While at work NONE or otherwise NONE	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) NONE		20f. (City or town) NONE (County) (State)	
21. I certify that I attended the deceased from APRIL , 19 59 , to PRES. , that I last saw the deceased alive on FEB. 24, 1961 , and that death occurred at 10³⁰ PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.		DATE SIGNED 2/25/61	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD.		2/25/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-1-61	22c. NAME OF CEMETERY OR CREMATORY ST JOHNS	22d. LOCATION (City, town, or county) (State) CLINTON, MD.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR MAR 2 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Shaver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARTHUR SHAWK JR. M.O. BRONCHITIS CLINTON, MO. 1901
Arthur Shawk Jr. M.O. BRONCHITIS CLINTON, MO. 1901

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April 24 1901
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HUBBARD CLINTON, MO.

FRANK GREEN ESTELLA JACKSON.
HOUSEWIFE NONE CLINTON, MO. 1901

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GERTRUDE BERTHA THOMAS
AUG. 30 1901 22 FEB. 22 01

CLINTON 1901
PRINCE GEORGE
HARVARD R. GEO.

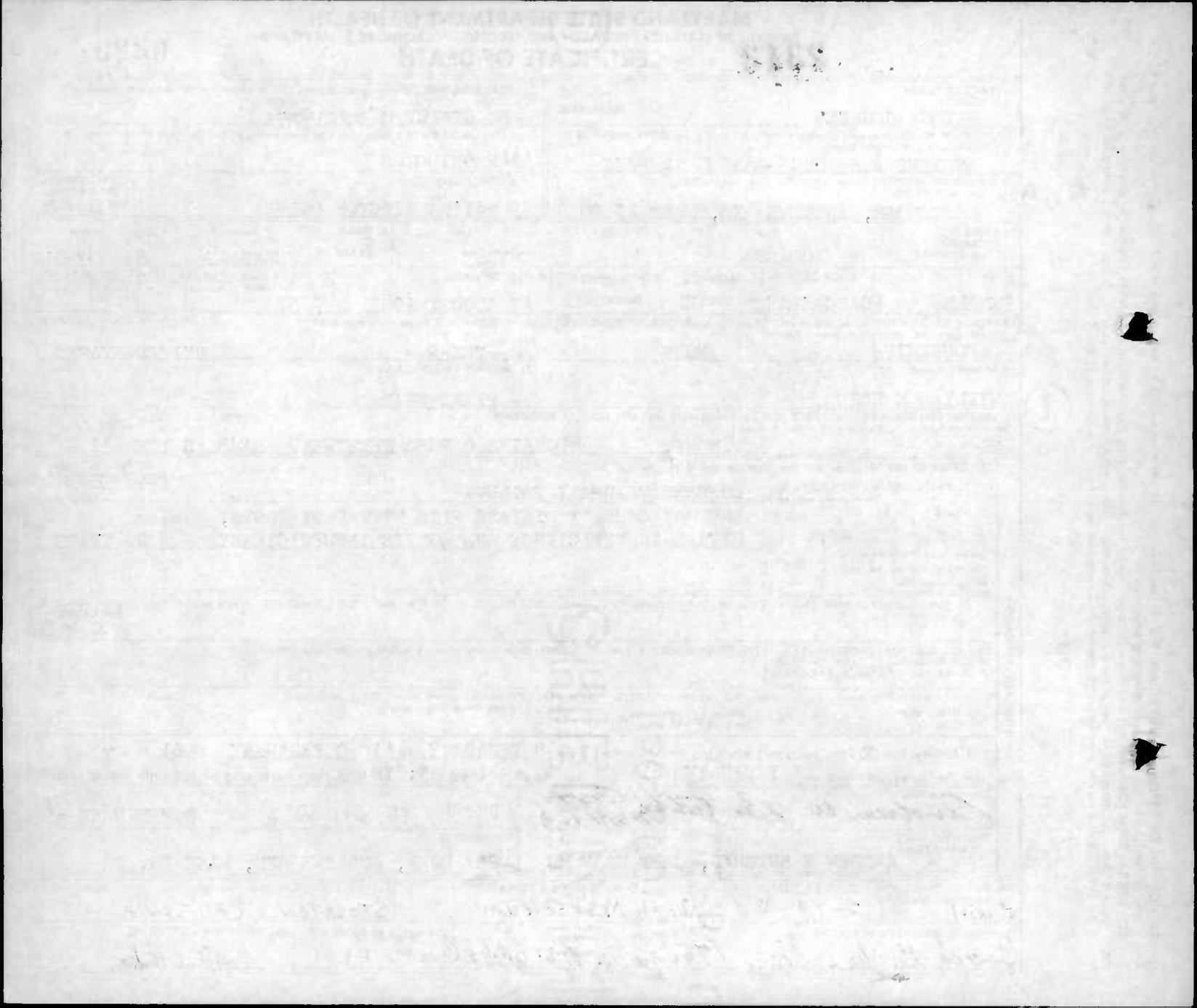
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02291

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP, ANDREWS AFB, WASH 25 DC		MARYLAND c. LENGTH OF STAY IN 1b 2 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 WASHINGTON d. STREET ADDRESS 6411 ABBINGTON DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ODESSA Middle M Last THYRET		4. DATE OF DEATH Month FEBRUARY Day 8 Year 19 61			
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 AUGUST 1903	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 57 Days 14 Hours 14 Min. 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) TEXAS	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME WILLIAM M HERD		14. MOTHER'S MAIDEN NAME PEARL WEAR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT LORRINE O SCHOTTLEUTNER Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS, Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) MITRAL INSUFFICIENCY AND AORTIC INSUFFICIENCY DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____				INTERVAL BETWEEN ONSET AND DEATH 10 YEARS 26 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 FEBRUARY, 19 61 , to 8 FEBRUARY, 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8 FEBRUARY 1961 , and that death occurred at 3:27 P from the causes and on the date stated above.					
22a. SIGNATURE <i>Andrew W. Butchko, Capt USAF MC</i>		22b. DATE 8 FEBRUARY 61		22c. PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO, CAPT USAF MC	
22d. ADDRESS USAF HOSP, ANDREWS AFB, WASH 25, DC		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-10-61		23c. NAME OF CEMETERY OR CREMATORY RURAL MAUSOLEUM	
23d. LOCATION (City, town, or county) (State) STOCKTON, CALIFORNIA		23e. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Hawley's Sons</i> ADDRESS 1756 Pa. Ave. N.W. Wash D.C.			
23f. DATE REC'D BY REGISTRAR FEB 14 '61		23g. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2314 CERTIFICATE OF DEATH

02292

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1/2 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John MAYLON Turner		4. DATE OF DEATH Month Day Year Feb 26 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 May 1898
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass. Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Peoples Drug Store	
11. BIRTHPLACE (State or foreign country) Raleigh, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown John Turner		14. MOTHER'S MAIDEN NAME Unknown Martha ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Paul C. Turner - son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/26 19 61 to 2/26 19 61 , that (I) (we) last saw the deceased alive on 2/26 19 61 , and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE Norman Doug Coman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Norman Doug Coman		22d. ADDRESS 3503 Penny St Mt Rainier Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/3/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE MAR 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

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First Oregon County

Cottage City

AND Cottage Friends

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ELIZABETH

WATSON

February 23, 1901

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U.S.A.

Clark

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George W. Menden

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2316

02294

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 5819 66th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle Augusta Last Watts				4. DATE OF DEATH Month February Day 22 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1905	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.		IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward Hutchinson				14. MOTHER'S MAIDEN NAME Effie Simpson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT George A Watts Address East Pines Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia set off 1 week 420.0 DUE TO Cerebral infarct 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterioscl. Hb. inf. (c) undet							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 15 1961 to Feb. 22 1961 , that (I) (we) last saw the deceased alive on Feb. 22 1961 , and that death occurred at 8:30 from the causes and on the date stated above.							
22a. SIGNATURE Benjamin S Miller				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) BENJAMIN S MILLER				22d. ADDRESS 3824-34th St Mt Rainier			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		25a. REC'D BY REGISTRAR FEB 27 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

2316

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF WITNESSES

DECLARATION OF DEATH
I, the undersigned, being a duly qualified Registrar of Births and Deaths for the District of ... do hereby certify that the above-named person died on the ... day of ... at the age of ... years, and that the cause of death was ...

CERTIFICATE OF DEATH

Reg. Dist. No. 02295

2317

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Belvoir - Adelphi</u>		c. LENGTH OF STAY IN 1b <u>10 1/2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>(none)</u> Last <u>Whaley</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Hampton</u>		14. MOTHER'S MARRIAGE NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Records of Point Branch Nurs. Home</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>generalized arteriosclerosis</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 18, 1961</u> to <u>February 18, 1961</u> , that I last saw the deceased alive on <u>February 18, 1961</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hans Wodak</u>		ADDRESS (Street, city or town, state) <u>9-E PARKWAY, GREENBELT, MD 2-86</u>	
PHYSICIAN'S NAME (Type) <u>HANS WODAK M.D.</u>		DATE SIGNED <u>9-E PARKWAY, GREENBELT, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington, D.C.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>55B 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

1917

I am a resident of the County of _____ State of _____

and hereby certify that _____

_____ died at _____

_____ on the _____ day of _____ 1917

at the age of _____ years

2318

CERTIFICATE OF DEATH

Reg. Dist. No. 02296

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>PR. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. LENGTH OF STAY IN 1b <u>13 Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8320 Old Fort Rd SE</u>				d. STREET ADDRESS <u>18320 Old Fort Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>James White</u>				4. DATE OF DEATH Month Day Year <u>Feb 2 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? 1893 68?</u> yrs.		9. AGE (In years last birthday) <u>68?</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>ROSALIE JACKSON, WASH., D.C.</u> Address <u>8320 Old Ft. Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> DUE TO <u>Hypertensive Heart Disease</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>24 hrs.</u> <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia 1957</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>57</u> , to <u>2/2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>61</u> , and that death occurred at <u>7:45 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7519 Broadview Rd S.E.</u> DATE SIGNED <u>2/2/61</u>							
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.				PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd</u> (Pr. Geo. County Md) <u>Wash 2/2/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-7-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Walters Field</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNTT Funeral Home, WALDORF, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RES

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02297

1. PLACE OF DEATH e. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4902 Quebec Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 4902 Quebec Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GLORIA BERNADINE WIEDEL		4. DATE OF DEATH Month February Day 13 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1930	9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months 30 Days 30 Hours 30 Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Branchville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul Edward Dement		14. MOTHER'S MAIDEN NAME Viola Elizabeth DeVilbliss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Kenneth E. Wiedel, Address 4902 Quebec St., College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO HANGING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 974X					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self from water pipe in basement		20c. TIME OF INJURY Month, Day, Year 4:00 p.m. 2-14-1961			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) College Park P.G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DATE SIGNED February 13, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-1961		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem	
22d. LOCATION (City, town, or country) (State) Bladensburg, Maryland		23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md		24a. REC'D BY REGISTRAR FEB 17 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns					

MEDICAL CERTIFICATION

THE
UNITED STATES

2310

Prince Georges County
College Park

3 Janis

College Park

1002 Jones Street

1002 Jones Street

RECEIVED

GEORGIA

Female White

Female White

Housewife

At home

1002 Jones Street

Paul Edward George

Male

Mr. Kenneth E. Wilson

College Park

1

January 3, 1961

JAN 11 1961

2-11-61
1002 Jones Street
College Park, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2320

CERTIFICATE OF DEATH

Reg. Dist. No. 2298

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5009 Cheyenne Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herbert Lawrence Wilkins				4. DATE OF DEATH Month Feb Day 8, Year 19 61-			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 3, 1893	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist				10b. KIND OF BUSINESS OR INDUSTRY Dept of Agriculture			
11. BIRTHPLACE (State or foreign country) Missouri				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Robert M Wilkins				14. MOTHER'S MAIDEN NAME Mary Mc Nary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. W W 1 none			
17. INFORMANT Inene D Wilkins				Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus							
19. INTERVAL BETWEEN ONSET AND DEATH 2 hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8 Feb , 19 61 , to 8 Feb , 19 61 , that I last saw the deceased alive on 8 Feb , 19 61 , and that death occurred at 9:05 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H David Kerr MD				ADDRESS (Street, city or town, state) 9812 49TH AVE			
PHYSICIAN'S NAME (Type) H. DAVID KERR, MD				DATE SIGNED 9 FEB 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb 13, 1961			
22c. NAME OF CEMETERY OR CREMATOR Arlington National				22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.			
24a. REC'D BY REGISTRAR FEB 10 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2321					02299					
1. PLACE OF DEATH a. COUNTY Prince Georges					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
c. LENGTH OF STAY IN 1b 9 months & 13 days					d. STREET ADDRESS 1701 Swann St., N.W., Apt #26					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John Wesley Williams					4. DATE OF DEATH 2 22 19 61					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/18		9. AGE (In years last birthday) 42 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver					10b. KIND OF BUSINESS OR INDUSTRY M.T. Broyhill Co., Arlington, Va.			11. BIRTHPLACE (County & State, or foreign country) North Carolina		
13. FATHER'S NAME Wesley Williams					12. CITIZEN OF WHAT COUNTRY? USA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 238-20-0053		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemoptysis DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) Pulmonary tuberculosis, far advanced, active					INTERVAL BETWEEN ONSET AND DEATH 5 minutes					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/9 1960, to 2/22/1961, that (I) (we) last saw the deceased alive on 2/22/1961, and that death occurred at 4:50 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Moe Weiss					22b. DATE SIGNED 2/22/61		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.			
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2/24/61		23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town or county) Smithfield		(State) N.C.		
24. FUNERAL DIRECTOR'S SIGNATURE R.N. Horton					ADDRESS 322 1/2 St. N.W.		25a. REC'D BY REGISTRAR DATE FEB 27 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

2322 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03510

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles G. Windsor</u>		4. DATE OF DEATH Month Day Year <u>FEB. 11 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-90</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen -----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>214-12-747444</u>	
17. INFORMANT Address <u>Rt #1, Box 491</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Hemia</u> DUE TO (b) <u>Renal Failure</u> DUE TO (c) <u>Shock from Cerebral Vascular Accident</u> CONDITIONS, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 29, 1961</u> , to <u>Feb. 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 11</u> 19 <u>61</u> , and that death occurred at <u>12:35</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>R. B. Sasscer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/12/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. B. Sasscer, M. D.</u>		22d. ADDRESS <u>Upper Marlboro, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/15/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Croom Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro</u>		25a. REC'D BY REGISTRAR <u>MAR 13 '61</u>	
ADDRESS <u>Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2323

02301

1. PLACE OF DEATH a. COUNTY PRINCE George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 13 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle J. Last WOLFROM				4. DATE OF DEATH Month FEB. Day 17 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-11	
9. AGE (In years lost birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19		11. IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER II, Bricklayer				10b. KIND OF BUSINESS OR INDUSTRY N.J.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph A. WOLFROM				14. MOTHER'S MAIDEN NAME ELLEN HARRINGTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 198-10-3104			
17. INFORMANT MR. EUGENIA WOLFROM				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intraventricular 442X DUE TO hypertensive AS. Sclerotic Ht. dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AS. Sclerotic Ht. dis. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from FEB. 12, 1961 , to FEB. 17, 1961 , that (I) (we) last saw the deceased alive on FEB. 17, 1961 , and that death occurred at 10:40 AM , from the causes and on the date stated above.							
22a. SIGNATURE DR. Sidney Lowry				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. SIDNEY LOWRY				22d. ADDRESS 7200 Marlboro Pike, S.E. Washington 28, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-21-61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat		23d. LOCATION (City, town, or county) (State) Arlington Va	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4 St NE				25a. REC'D BY REGISTRAR FEB 21 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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STATE OF DEATH



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>73</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10128 RIGGS ROAD</u>			d. STREET ADDRESS <u>10128 RIGGS ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CAROLINE</u> Middle <u>L.</u> Last <u>YOBST</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>23</u> Year <u>1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 26, 1889</u>	9. AGE (In years lost birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>HENRY KERN</u>		
14. MOTHER'S MAIDEN NAME <u>CATHERINE YOGEL</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>VIVIAN YOBST</u> Address <u>10128 RIGGS ROAD HYATTSVILLE, MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>443X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 gm.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of uterus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 24, 1960</u> to <u>Feb. 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1961</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Thomas J. Kelly</u>			22b. DATE SIGNED <u>Feb. 27, 1961</u>		
22c. PHYSICIAN'S NAME (Type) <u>THOMAS J. KELLY, M.D.</u>			22d. ADDRESS <u>64807 H. Ave., Takoma Park, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-27-61</u>		23b. DATE THEREOF <u>2-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln</u>	
23d. LOCATION (City, town, or county) (State) <u>Calverton Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>See Funeral Home 300-4 St N.E. Wash D.C.</u>			25a. REC'D BY REGISTRAR DATE <u>FEB 27 1961</u>		
25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>					

3851

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

1912

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]